

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 12314 76

1. PLACE OF DEATH:

County Severn
City or town Frederickburg, R.D. No. 1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death 23 1/2 years
Hospital, institution, or street address where death occurred:
Dead at his home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Cecil
City or town Phiksburg (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2. (a) If veteran, name war _____

3. (a) FULL NAME

James M. Abbott

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Marafilla Hare
Abbott 6. (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) July 11 - 1875

8. AGE: Years 73 Months 4 Days 11 If less than one day _____ hrs. _____ min.

9. Birthplace Frederickburg, Caroline Co. Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business own other

12. Name Marafilla Hare

13. Birthplace Maryland

14. Maiden name Martha Slater

15. Birthplace Maryland

16. Informant Elizab. Abbott

Address Frederickburg, R.D. 1

17. Burial Burial Date thereof Dec 24/48
(Burial, cremation, or other) (month) (day) (year)

Cemetery or crematory Emory Cemetery Co. Md.

Location Cecil Co. Md.

18. Funeral director Edw. J. Sipton

Address Hampstead, Md.

19. (Date rec'd by registrar) 12 27 48 Registrar J. Woodward

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 22nd 19 48

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1st 19 46 to Dec 22 19 48
and that I last saw him live on Dec 15 19 48
Immediate cause of death Cerebral thrombosis
or hage

Due to Organ

Due to _____

Other conditions _____

(include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE John J. Stewart M. D. or other 1948

Address Westminster Md. Date signed Dec 22

MARGIN RESERVED FOR BINDING

VS A15 9-45-11-V

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 30 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12317

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll
 City or town Rural - Sykesville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 yrs. 5 mo 5 days
 Hospital, institution, or street address where death occurred:
Springfield State Hospital
 How long in hospital or institution? Employee

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State South Carolina County York Co
 City or town Rock Hill
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R. P. D. #1
 (If rural, give LOCATION)
 2. (a) If veteran, name war ☒

3. (a) FULL NAME

Joseph Oscar Armstrong

3. (b) Social Security Number

248-22-3171

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Sen. Mabel Armstrong
nee Holt 6. (c) If alive, give age 68 years
 7. Birth date of deceased (mo., day, yr.) October 6 - 1887
 8. AGE: Years 61 Months 1 Days 29 If less than one day
hrs. min.

9. Birthplace Belmont, Gaston, N. C.
 (Town, county, and state)

10. Usual occupation Farmer - (Recently attendants)

11. Industry or business

12. Name James Matthews Armstrong

13. Birthplace North Carolina

14. Maiden name Clarissa Ford

15. Birthplace North Carolina

16. Informant Wife Mrs. Sen. M. Armstrong

Address The Oaks R.V. York, S. C.

17. Burial Date thereof 12-6-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greenwood

Location Belmont, N. C.

18. Funeral director C. Harry Eaves

Address Sykesville, Md.

19. Dec 5 19 48 C. Harry Eaves
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4, 19 48 at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 3, 19 48 to Dec. 4, 19 48 and that I last saw him alive on Dec. 4, 19 48

Immediate cause of death Coronary thrombosis DURATION 1 day

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joseph H. Marshall, M.D. M. D. or other

Address Springfield State Hospital Date signed 12/4/48

RECEIVED

DEC 7 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

12318

74

1. PLACE OF DEATH:

County Carroll
 City or town Sykesville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? since 12-15-47
 Hospital, institution, or street address where death occurred:
Springfield State Hospital
 How long in hospital or institution? since 12-15-47

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4352 Shamrock Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

AUMILLER, Paul Frank

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced divorced
 6.(b) Name of husband or wife Dora Link
 6.(c) If alive, give age 69 years
 7. Birth date of deceased (mo., day, yr.) 5-7-85
 8. AGE: Years 63 Months 7 Days 5 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore City
 (Town, county, and state)
 10. Usual occupation Janitor
 11. Industry or business _____
 12. Name John Aumiller
 13. Birthplace Germany
 14. Maiden name Barbara Lang
 15. Birthplace Germany

16. Informant John A Aumiller
 Address 4352 Shamrock Ave
 17. BURIAL Date thereof DEC 15 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory HOLY REDEEMER
 Location 4300 BELAIR RD.
 18. Funeral director THE DIPPEL BROTHERS
 Address 1800 E LOMBARD ST
 19. 12-13-48
 (Date rec'd by registrar) Registrar [Signature]

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12 19 48, at 9:05 P. M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 29 19 48 to December 12 19 48
 and that I last saw him alive on December 12 19 48
 Immediate cause of death Arteriosclerosis
 DURATION 6 yrs
 Due to _____
 Due to _____
 Other conditions Cerebral arteriosclerosis 1 yr
Laennec cirrhosis 5 yrs
 (Include pregnancy within 8 months of death)
 Major findings of operations _____
 Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
Martin Gross, M.D.
 23. SIGNATURE Martin Gross, M.D. M. D. or other _____
 Address Sykesville, Md. Date signed 12-12-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 93d

12319

74

1. PLACE OF DEATH:

County CARROLL
 City or town Sykesville
 (If outside city or town limits, write RURAL and give nearest town)
 Now long in above place of death? 1 month, 6 days
 Hospital, institution, or street address where death occurred:
Springfield State Hospital
 Now long in hospital or institution? 1 month, 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 829 Park Avenue
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

ELIZABETH BALDWIN

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife _____
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) August 31, 1875
 8. AGE: Years 73 Months 3 Days 29 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)
 10. Usual occupation None
 11. Industry or business _____
 12. Name Abram S. Baldwin
 13. Birthplace Maryland
 14. Maiden name Martha E. Streett
 15. Birthplace Maryland

16. Informant Record, Springfield State Hospital
 Address Sykesville, Maryland
 17. Burial Date thereof Jan 3, 1949
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory St. John's
 Location Kingsville Md.
 18. Funeral director A. H. Means & Son
 Address 805 N. Calvert St. Balt. Md.
 19. Dec 31 19 48 Cathy Keen
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30 19 48 at 3:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
November 24 19 48 to December 30 19 48
 and that I last saw him/her alive on December 30 19 48

Immediate cause of death cerebral vascular accident DURATION 2 days

Due to Hypertensive cardiovascular disease associated with cerebral arteriosclerosis many years

Other conditions Psychosis with cerebral arteriosclerosis many years
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
 Manner of injury _____ Injured at work? _____

23. SIGNATURE The Mayor M. D. or other _____
 Address Sykesville, Maryland Date signed 12/30/48

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED

RECEIVED

RECEIVED

RECEIVED

JAN 4 1949

BUREAU V. S.

EVIDENCE FOR ADDITION
IN # 22 SHOW N ON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Rec

12320

FILM No. G 118 JAN 25 1949 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll
City or town Rural - Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2.5 days
Hospital, institution, or street address where death occurred Springfield State Hospital
How long in hospital or institution? 2.5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Ind. County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4307 Clifton Road
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Harold Henry Ballard

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife Elise Baugh
7. Birth date of deceased (mo., day, yr.) July 26, 1868
6. (c) If alive, give age years
8. AGE: Year 80 Months 5 Day 5 If less than one day hrs. min.

9. Birthplace Baltimore, Ind.
(Town, county, and state)
10. Usual occupation Professor of mathematics
11. Industry or business
12. Name George E. Ballard
13. Birthplace Somerset Co., Ind.
14. Maiden name Mary S. Day
15. Birthplace Somerset Co., Ind.

18. Informant Hospital records
Address

17. Burial Date thereof Jan. 4, 1949
(Burial, cremation, or removal, which?) (month) (day) (year)
Cemetery or crematory Druid Ridge
Location Pikesville, Ind.

18. Funeral director William Coors Inc.
Address 217 St. Paul St. Baltimore

19. Jan 1 19 49 C. Harry Keer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31, 1948 at 9:50 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 6, 1948 to Dec. 31, 1948
and that I last saw him alive on Dec. 31, 1948
Immediate cause of death Terminal
Bronchopneumonia
Generalized arteriosclerosis
Due to Myocardial degeneration
Due to
Other conditions Fracture of left hip
Psychosis with cerebral arteriosclerosis
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

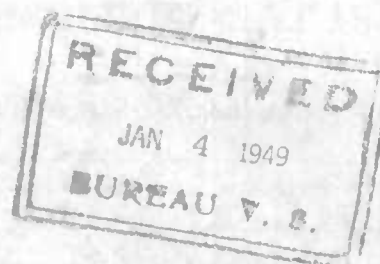
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of Dec 14, 1948
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Yes
Means of injury Accidental fall Injured at work? Yes

23. SIGNATURE Joseph H. Marshall, M.D.
Address Springfield State Hospital Date signed 1/1/49
M.D. or other

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12321

Reg. Dist. No. 76

1. PLACE OF DEATH:

County... Carroll Co.
 City or town... Westminster, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... about 30 years
 Hospital, institution, or street address where death occurred:
38 Penna. Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Carroll
 City or town... Westminster
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... 38 Penna. Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war...

3. (a) FULL NAME

George David Barnhart
 4. Sex M. 5. Color or race W. 6.(a) Single, married, widowed, or divorced Widowed

3. (b) Social Security Number

214,01,0505

6.(b) Name of husband or wife... Grace E. Lowe Barnhart
 7. Birth date of deceased (mo., day, yr.) Sept. 30 1877
 8. AGE: Years 71 Months 2 Days 27 It less than one day hrs. min.

6.(c) If alive, give age... years
 9. Birthplace... near Westminster, Carroll Co. Md.
 (Town, county, and state)

10. Usual occupation... Car. salesman (retired)
 11. Industry or business

12. Name... John Barnhart
 13. Birthplace... Carroll Co. Md.

14. Maiden name... Mary Stephan
 15. Birthplace... Carroll Co. Md.

16. Informant... Gertrude Barnhart
 Address... 38 Penna. Ave. Westminster, Md.

17. Burial... Burial Date thereof... Dec 30, 48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Leisters Cemetery
 Location... near Westminster, Md.

18. Funeral director... J. E. Meyers, Jr.
 Address... Westminster, Md.

19. 12/27 48 L. K. Woodward
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Dec. 27 1948 at 8:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945 to Dec 27 - 1948
 and that I last saw him alive on Dec 26 - 1948

Immediate cause of death... Myocarditis (chr)
Hypertension (acute)

Due to...
 Due to...

Other conditions...

(Include pregnancy within 8 months of death)

Major findings of operations... None Date of op...

Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... None Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

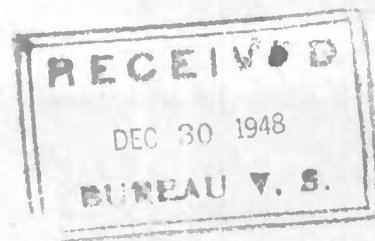
23. SIGNATURE... W. C. Jesmuth M. D. or other
 Address... Westminster, Md. Date signed... 12-27-48

MARGIN RESERVED FOR BINDING

VS A15

9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12322

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll
 City or town Rural Westminster
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs.
 Hospital, institution, or street address where death occurred:

Glover Nursing Home

How long in hospital or institution? 2 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Carroll
 City or town Rural Uniontown
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Ella Mary Belt

3. (b) Social Security Number

None

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

Josiah Belt

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) June 17 - 1872

8. AGE:

Years

Months

Days

If less than one day

76

5

16

hrs.

min.

9. Birthplace Harrisburg, Pa.
 (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name McGowan

13. Birthplace Not known

MOTHER 14. Maiden name _____

15. Birthplace _____

16. Informant H.M. Schew

Address Union Bridge, Md.

17. Burial Dec 6-1948
 (Burial, cremation, or removal) Which? (month) (day) (year)

Cemetery or crematory Pipe Creek Methodist Cem.

Location Wakfield Carroll Co. Md.

18. Funeral director A. Bankard & Son

Address Westminster, Md.

19. 12/4/48 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3 1948 at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 3 1948 and that I last saw him alive on Dec 3 1948

Immediate cause of death Excessive hemorrhage

DURATION

1 day

Due to Arterio-sclerotic C.V. disease year

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

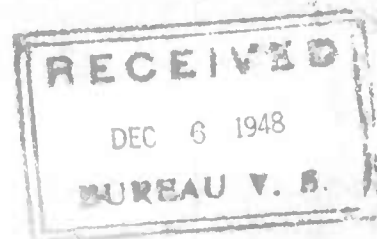
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE James T. Mank M. D. or other

Address Westminster Md Date signed 12/4/48



RECEIVED

DEC 6 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12323

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 months, 25 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 8 months, 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll
City or town Eldersburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2(a) If veteran, name war _____

3. (a) FULL NAME

WILLIAM ASBURY BENNETT

3. (b) Social Security Number

213-18-9178

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced S

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) 3/1/02 6. (c) If alive, give age _____ years

8. AGE: Years 46 Months 9 Days 21 If less than one day _____ hrs. _____ min.

9. Birthplace Carroll County, Maryland
(Town, county, and state)

10. Usual occupation Farm Hand

11. Industry or business _____

12. Name George A. Bennett

13. Birthplace Montgomery County, Maryland

14. Maiden name Hattie Leatherwood

15. Birthplace Carroll County, Maryland

16. Informant Record, Springfield State Hospital

Address Sykesville, Maryland

17. Burial Date thereof 12-24-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Old Oakland

Location Oakland Mills, Carroll Co., Md.

18. Funeral director C. Harry Wheeler

Address Sykesville, Md.

19. Dec. 23, 1948 C. Harry Wheeler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22 19 48 at 7:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 27 19 48 to December 22 19 48 and that I last saw him alive on December 22 19 48

Immediate cause of death Hemorrhagic Infarcts of Right and Left lung (Fat Emboli) DURATION 12-19-48

Due to Fracture of femur 12-19-48

Other conditions Psychosis with mental deficiency
(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results Multiple Infarcts of lungs - Date of op. _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 12-19-48

Where did injury occur? Springfield State Hospital, Sykesville, Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury Slipped and fell Injured at work? _____

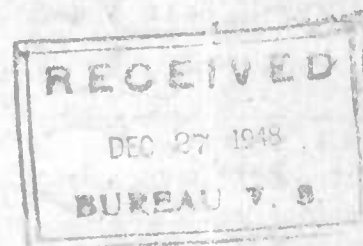
23. SIGNATURE M. Virginia Beyer M.D. or other _____

Address Sykesville, Maryland Date signed 12/22/48

MARGIN RESERVED FOR BINDING

VS 475 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12324

Reg. Dist. No. 76

1. PLACE OF DEATH:

County..... Carroll
 City or town..... Rural Westminster
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... life
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County..... Carroll
 City or town..... Rural Westminster
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Route 4
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Barbara Bitzel3. (b) Social Security Number
none

4. Sex..... female 5. Color or race..... white 6. (a) Single, married, widowed, or divorced..... widowed
 6.(b) Name of husband or wife..... Philip P. Bitzel 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... January 29, 1868
 8. AGE: Years..... 80 Months..... 10 Days..... 14 If less than one day..... hrs. min.
 9. Birthplace..... Carroll County, Md.
 (Town, county, and state)
 10. Usual occupation..... none
 11. Industry or business.....

FATHER
 12. Name..... Frederick Reuther
 13. Birthplace..... Germany
 MOTHER
 14. Maiden name..... Margaretha Mason
 15. Birthplace..... Germany
 16. Informant..... Mrs. Thomas Fowler
 Address..... Westminster, Md.
 17. burial Date thereof..... 12/16/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Leister's Cemetery
 Location..... Westminster, Md. R.D.
 18. Funeral director..... J. Francis Reese
 Address..... Westminster, Md.
 19. 12/15 48 L. Woodworth
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... December 13 19 48 at 12 noon M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 12 19 48 to 13 19 48
 and that I last saw h. or alive on Dec 12 19 48

Immediate cause of death..... Carcinoma of thyroid (right) DURATION..... ??
 Due to..... General
 Due to..... Carcinomatous

Other conditions.....
 (Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE..... Julius Chopko M. D. or other
 Address..... 820 W. Main Westminster, Md. Date signed..... 12/16/48

RECEIVED
DEC 17 1948
BUREAU V. C.

RECEIVED
DEC 17 1948
BUREAU V. C.

RECEIVED
DEC 17 1948
BUREAU V. C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12325

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll
 City or town Henryton, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 Days
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
 How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Baltimore 17, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 903-N. Gilmore Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

David Samuel Blagmond

3. (b) Social Security Number

4. Sex Male 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Leah Blagmond
 (b. (c) If alive, give age 45 years
 7. Birth date of deceased (mo., day, yr.) December 5, 1937
 8. AGE: Years 61 Months 6 Days 0 If less than one day 13 hrs. 0 min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)

10. Usual occupation Lumberman

11. Industry or business

MOTHER: 12. Name Robert Blagmond
 13. Birthplace Virginia
 14. Maiden name Maggie Dixon
 15. Birthplace Virginia

16. Informant Deceased
 Address

17. Burial Date thereof Dec 26th/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory mt Auburn
 Location Elroy O Wilson

18. Funeral director Brantley &
 Address 1000

19. December 18, 1948
 (Date rec'd by registrar) Alfred R. Brantley Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18, 1948 at 6:55 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 23, 1948 to December 18, 1948 and that I last saw him alive on December 18, 1948

Immediate cause of death Pulmonary Tuberculosis
 DURATION October 1948

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other

Address Henryton, Maryland Date signed 12-18-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

200a

12326

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll
City or town Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll
City or town Westminister
(If outside city or town limits, write RURAL and give nearest town)
Street No. 45 Giles Street
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

John Edward Boyer

3. (b) Social Security Number

4. Sex Male 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife
6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) July 22, 1881

8. AGE: Year 67 Month 4 Day 16 If less than one day _____ hr. _____ min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual occupation laborer

11. Industry or business

12. Name Balus Boyer

13. Birthplace Maryland

14. Maiden name Annie B. Brooks

15. Birthplace Maryland

16. Informant Deceased

Address

17. Burial Date thereof Dec 11, 48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Elkwood Cem.

Location near Westminister Md.

19. Funeral director J. E. Myers, Jr.

Address Westminister, Md.

19. December 8, 1948 Albert R. Swannick
(Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 8, 1948 at 2:20 P.

21. I CERTIFY that death occurred on the data above stated; that I attended deceased from December 3, 1948 to December 8, 1948 and that I last saw him alive on December 8, 1948

Immediate cause of death Acute Heart Failure

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Neuse Hoffman, M.D. M. D. or other

Address Henryton, Maryland Date signed 12-8-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 11 1948

BUREAU Y. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll
 City or town Henryton, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 months, 26 days
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
 How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County
 City or town Baltimore 1,
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 585 Oxford Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war ✓

3. (a) FULL NAME

Zello Marie Brown

3. (b) Social Security Number

4. Sex female 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Divorced
 6. (b) Name of husband or wife
 7. Birth date of deceased (mo., day, yr.) April 18, 1918
 8. AGE: Years 30 Months 8 Days 1 If less than one day hrs. min.
 8. (c) If alive, give age years

9. Birthplace Petersburg, Virginia
 (Town, county, and state)

10. Usual occupation Waitress

11. Industry or business

12. Name Ollie Coleman

13. Birthplace Virginia

14. Maiden name Sylvia Watkins

15. Birthplace Virginia

18. Informant Deceased

Address Removal

17. (Burial, cremation, or removal. Which?) Date thereof 12-22-48
 (month) (day) (year)

Cemetery or crematory Baltimore City mosque

Location Baltimore Maryland

18. Funeral director Mrs Samuel T. Hamby

Address 578 W. Biddle Street

19. December 19, 1948 Albert R. Swann
 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19, 1948 at 7:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 24, 1948 to December 19, 1948
 and that I last saw him alive on December 19, 1948

Immediate cause of death Pulmonary Tuberculosis

DURATION

May
1948

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul H. Hoffman, M.D. M. D. or other

Address Henryton, Maryland Date signed 12-19-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

49a Bu

12328

Reg. Dist. No. 74

1. PLACE OF DEATH: Carroll
County..... Sykesville
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years, 8 months, 2 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 6 years, 8 months, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County EXXXXXI
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2132 W. Fayette Street
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3.(a) FULL NAME Fannie G. BURDETTE

3.(b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife Thomas Burdette
6.(c) If alive, give age unknown years
7. Birth date of deceased (mo., day, yr.) April 15, 1863
8. AGE: Years Months Days If less than one day
85 7 25 hrs. min.

9. Birthplace Finksburg, Maryland
(Town, county, and state)
Housewife
10. Usual occupation
11. Industry or business

12. Name Washington Hanson Ward
13. Birthplace Finksburg, Maryland
14. Maiden name Lattisia M. Stockdale
15. Birthplace Finksburg, Maryland

16. Informant Hospital records
Address Springfield State Hospital

17. Burial Date thereof Dec. 14, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Springfield Hospital Cem.
Location Sykesville, Md.

18. Funeral director Harry Heer
Address Sykesville, Md.

19. Dec. 13, 1948 Harry Heer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 10, 1948 1.15p
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 23, 1942 to December 10, 1948
and that I last saw him alive on December 10, 1948

Immediate cause of death
Coronary occlusion
19 days
xxx Abdominal tumor, probably
Due to malignant ovarian cyst about 2 years
Due to

Other conditions
Senile psychosis, simple
deterioration about 7 years
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Irene Holzman, M.D.
Springfield State Hospital 12-10-48
Address Date signed

RECEIVED

DEC 15 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County... Carroll
 City or town... Finksburg, Route 1
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... life
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Carroll
 City or town... Finksburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. ... Route 1
 (If rural, give LOCATION)
 2. (a) If veteran, name war... none

3. (a) FULL NAME

Jacob F. Caple

3. (b) Social Security Number

none

4. Sex... male 5. Color or race... white 6. (a) Single, married, widowed, or divorced... widowed
 6. (b) Name of husband or wife... Mary E. Caple
 7. Birth date of deceased (mo., day, yr.)... October 29, 1856
 8. AGE: Years... 92 Months... 1 Days... 2 If less than one day... hrs. ... min.

9. Birthplace... Carroll County, Maryland
 (Town, county, and state)
 10. Usual occupation... farmer
 11. Industry or business

FATHER 12. Name... William H. Caple
 13. Birthplace... Maryland
 MOTHER 14. Maiden name... Susan Brothers
 15. Birthplace... Maryland

16. Informant... Miss Evelyn Caple
 Address... Finksburg 1, Md.

17. burial Date thereof... 12/4/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory... Carrollton Church of God
 Location... Carrollton, Md.

18. Funeral director... J. Francis Reese
 Address... Westminster, Md.

19. 12/2 48 W. J. Williams
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... December 1 19 48 at 10:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Nov. 24 19 48 to Dec 1 19 48
 and that I last saw him alive on Dec 1 19 48

Immediate cause of death... Acute Pneumonia
 DURATION... 7 days

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

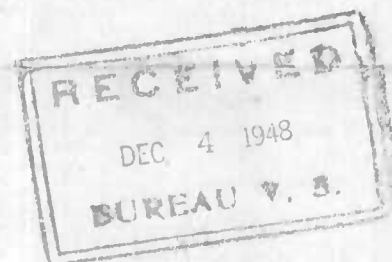
23. SIGNATURE... Plutus Ban

Address... Westminster, Md. M. D. or other...
 Date signed... 12/2/48

MARGIN RESERVED FOR BINDING

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 83

1. PLACE OF DEATH: Carroll
County..... Woodbine
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 6 years
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Maryland..... County..... Carroll
City or town..... Woodbine
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME
JAMES E. CLARK

3. (b) Social Security Number

4. Sex Male
5. Color or race White
6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife Anna R. Clark
deceased
7. Birth date of deceased (mo., day, yr.) April 29, 1868
6. (c) If alive, give age..... years
8. AGE: Years 80 Months 8 Days 0
If less than one day..... hrs. min.

9. Birthplace Frederick Co. Maryland
(Town, county, and state)
10. Usual occupation Farmer

11. Industry or business retired
Miller Clark

12. Name Maryland
13. Birthplace Margaret ?

14. Maiden name Maryland
15. Birthplace Mr. J. Millard Clark

16. Informant Woodbine, Md.
Address

17. Burial 1-1-1949
(Burial, cremation, or removal, which?) Date thereof.....
(month) (day) (year)
Cemetery or crematory United Bretheran
Thurmont, Maryland
Location C. M. Waltz

18. Funeral director Winfield, Md.
Address

19. Dec 31 48 Edua M. Hewlett
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29, 1948 19..... at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6, 1948 19..... to December 29, 1948 19.....
and that I last saw him alive on December 28, 1948 19.....

Immediate cause of death Anjina Pectoris
DURATION 4 weeks

Due to Coronary Sclerosis 16 mo

Due to

Other conditions Chronic Myocarditis 3 yrs

(Include pregnancy within 3 months of death)

Major findings of operations none Date of op.

Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Stanley Grabill M. D. o
Address Mt. Airy, Md. Date signed 12/30/48

RECEIVED

FEB 11 1949

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

12331

72

1. PLACE OF DEATH:

County Carroll
 City or town Rural, Westminster, R.D. 2
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 50 years
 Hospital, institution, or street address where death occurred:
Myers District, Near Union Mills
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll
 City or town Rural Westminster, R.D. 2
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Myers District, Near Union Mills
 (If rural, give LOCATION)
 2.(d) If veteran, name war

3. (a) FULL NAME

Frances Elizabeth Crowl

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife John W. Crowl
 6. (c) If alive, give age 77 years
 7. Birth date of deceased (mo., day, yr.) May 26 1866
 8. AGE: Years 82 Months 6 Days 23 If less than one day
 hrs. min.

9. Birthplace Carroll County, Md.
 (Town, county, and state)
 10. Usual occupation Housework
 11. Industry or business Housewife
 12. Name Henry Flickinger
 13. Birthplace Carroll County, Md.
 14. Maiden name Frances Ann Humbert
 15. Birthplace Carroll County, Md.

16. Informant John W. Crowl
 Address Westminster, Md. R. D. 2
 17. Burial Date thereof 12/21/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St. Marys Union Cemetery
 Location Silver Run, Md.
 18. Funeral director J. W. Little & Son, P.O. R.A. Little
 Address Littlestown, Pa.

19. Dec. 20th 19 48 Calvin B. Bantex
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19 19 48, at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dec. 15 19 48 to Dec. 19 19 48
 and that I last saw him alive on Dec. 17 19 48

Immediate cause of death Chronic myocarditis
 DURATION 6 months

Due to Senility 6 mo.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE L. L. Potts M.D.

M. D. or other

Address Littlestown, Pa. Date signed 12-20-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12332

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll
 City or town Henrington, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 months, 16 days
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch
 How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's
 City or town District Heights (Wash. D.C.) P.O.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 998- County Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war. ☒

3. (a) FULL NAME

William Davage

3. (b) Social Security Number

4. Sex Male 5. Color or race Col. 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Pearl Davage
 6.(c) If alive, give age 52 years
 7. Birth date of deceased (mo., day, yr.) December 17, 1889
 8. AGE: Year 58 Month 11 Days 23 It less than one day hrs. min.

9. Birthplace Forestville, Md.
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

MOTHER FATHER
 12. Name Samuel Davage
 13. Birthplace Tennessee
 14. Maiden name Georgiana Nichols
 15. Birthplace Maryland

16. Informant Deceased

Address

17. Burial Date thereof Dec. 13-1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Mt. Calvary Catholic
Forestville Md.
 Location

18. Funeral director Henry S. Washington, SonAddress #67 N. 1st. NW Wash. D.C.

19. December 2, 1948
 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2, 1948 at 1:45 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
February 16, 1948 to December 2, 1948

and that I last saw him alive on December 2, 1948

Immediate cause of death Pulmonary Tuberculosis DURATION November 1945

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other

Address Henrington, Maryland Date signed 12-9-48

RECEIVED
DEC 11 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 76

12333

1. PLACE OF DEATH:

County Carroll
 City or town Westminster
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll
 City or town Westminster
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 13 Milton Avenue
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Daisy May DeLong3. (b) Social Security Number
none

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

female white widowed

6. (b) Name of husband or wife Preston A. DeLong7. Birth date of deceased (mo., day, yr.) May 11, 1874

8. AGE: Years 74 Months 6 Days 23 It less than one day hrs. min.

9. Birthplace Lancaster, Pa.
(Town, county, and state)10. Usual occupation none

11. Industry or business

12. Name Abram Setley13. Birthplace Penna.14. Maiden name Elizabeth Kuchel15. Birthplace Penna.16. Informant Alfred de LongAddress Westminster, Md.17. burial Date thereof 12/7/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Watson town CemeteryLocation Watson town, Pa.18. Funeral director J. Francis ReeseAddress Westminster, Md.19. 12/6 48 J. Woodward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH December 4 19 48 at 2 1/2 p. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 4 19 48 to December 4 19 48 and that I last saw him alive on December 4 19 48Immediate cause of death Chronic Cerebral Arteriosclerosis DURATION 7 hours
Due to Chronic Hypertensive Disease 3 yearsDue to
Other conditions
(Include pregnancy within 3 months of death)Major findings of operations
Date of op.Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?23. SIGNATURE Dr. B. B. Bon M. D. or other
Address Westminster, Maryland Date signed 12/5/48

RECEIVED

DEC 8 1948

BUREAU F. B. I.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

County Carroll
 City or town New Windsor
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Lifetime
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Charles Edward Hewilbiss

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower
 6. (b) Name of husband or wife Elyzabeth Engel
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, y.) March 25 - 1858
 8. AGE: Years 90 Months 8 Days 14 If less than one day _____ hrs. _____ min.

9. Birthplace Carroll County, Md.
(Town, county, and state)10. Usual occupation Retired11. Industry or business Farmer12. Name Charles Hewilbiss13. Birthplace Maryland14. Maiden name Mary Engel15. Birthplace Maryland16. Informant Margaret EngelAddress New Windsor Md17. Burial Date thereof Dec. 12 - 48
(Burial, cremation, or removal. Which? (month) (day) (year))Cemetery or crematory Bethel CemeteryLocation Carroll County, Md.18. Funeral director W. W. Hartley & SonsAddress Union Bridge & New Windsor Md19. Dec 10 1948 Ernest Brunet
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)
 State Maryland County Carroll
 City or town New Windsor
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2. (a) If veteran, name war _____

MEDICAL CERTIFICATION

20. DATE OF DEATH December 8, 1948, at 9:00 P. M.21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Jan 1, 1948 to Dec 8, 1948and that I last saw him alive on Jan 1, 1948Immediate cause of death arteriosclerotic heart disease DURATION 3 daysDue to 1 yr +

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Charles WilbissAddress Washington Date signed Dec 10, 1948

RECEIVED

DEC 16 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

12335

1. PLACE OF DEATH:

County Carroll
 City or town Henryton, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 year, 6 months, 19 days
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
 How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel
 City or town Camp Parole
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____ ✓

3. (a) FULL NAME

Emma Eades

3. (b) Social Security Number

4. Sex female 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Separated
 6. (b) Name of husband or wife John Eades
 7. Birth date of deceased (mo., day, yr.) August 26, 1892 8. (c) If alive, give age 84 years
 8. AGE: Years 56 Months 3 Days 20 If less than one day _____ hrs. _____ min.

9. Birthplace Severn, Maryland
 (Town, county, and state)
 10. Usual occupation None
 11. Industry or business _____
 12. Name Albert Jennings
 13. Birthplace (unknown)
 14. Maiden name Elizabeth Day
 15. Birthplace Severn, Maryland

16. Informant Deceased
 Address _____
 17. Burial Date thereof 12-19-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Asbury Cem.
Annapolis, Maryland
 Location William Reese, Jr.
 18. Funeral director 108 Washington St. - Annapolis
 Address Albert R. Smith
 19. December 16, 1948 (Date rec'd by registrar) Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16, 1948 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27, 1947 to December 16, 1948
 and that I last saw her alive on December 16, 1948

Immediate cause of death Pulmonary Tuberculosis DURATION June 1945

Due to _____
 Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Resden Hoffman, M.D. M. D. or other _____
 Address Henryton, Maryland Date signed 12-16-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12336

Reg. Dist. No. 80.

1. PLACE OF DEATH:

County CarrollCity or town New Windsor
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8.0 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County CarrollCity or town New Windsor
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

John Maurice Ecker

3. (b) Social Security Number

7 and

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Margaret Beizer Ecker

7. Birth date of

deceased (mo., day, yr.)

July 26 - 18706. (c) If alive, give age 81 years

8. AGE:

Years 78Months 4Days 7

If less than one day

hrs. _____ min.

9. Birthplace

Fred. Co. Md.
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER
MOTHER

12. Name

James E. Ecker

13. Birthplace

Fred. Co. Md.

14. Maiden name

Margaret Beizer

15. Birthplace

Fred. Co. Md.

16. Informant

Margaret Ecker

Address

New Windsor, Md.

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

Dec. 13, 1948
(month) (day) (year)

Cemetery or crematory

Windsor Cemetery

Location

New Windsor, Md.

18. Funeral director

H. B. Bankard & Son

Address

Windsor, Md.

19.

Dec 14 1948
(Date rec'd by registrar)Ernest B. Burt

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13 1948 at 3:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 15 1948 to Dec. 13 1948and that I last saw him alive on Dec 11 1948

Immediate cause of death

Cerebral Thrombosis

Due to

arteriosclerotic C.V.D.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

Merritt E. Ralston

M. D. or other _____

Address New Windsor, Md. Date signed Dec. 13, 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 16 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

12337

93d

76

1. PLACE OF DEATH:

County Carroll
City or town Hinksburg Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Hinksburg - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Amos Ezra Evans

3. (b) Social Security Number

4. Sex MA 5. Color or race W 6. (a) Single, married, widowed, or divorced widower

6. (b) Name of husband or wife May Leather
6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 2 - 1866

8. AGE: Years 82 Months - Days 28 If less than one day hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Harmer

11. Industry or business

12. Name Noah Evans

13. Birthplace md

14. Maiden name May J. Campbell

15. Birthplace Ind

16. Informant Amos Evans

Address Hinksburg Md

17. Burial Date thereof Jan 1/49
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Bethel

Location Carroll Co. Md

18. Funeral director Edw. J. Tipton

Address Hampstead Md

19. 1/1 18 45 Howard
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30, 1948 at 9 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 12, 1948 to Dec 30, 1948 and that I last saw him alive on Dec 29, 1948

Immediate cause of death Ischemic

Due to Cerebral

Due to Chronic Myocarditis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Edw. J. Tipton
M. D. or other

Address Hampstead Md Date signed 12/30/48

MARGIN RESERVED FOR BINDING

9-45-154

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 5 1949

BUREAU ^W T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12338
Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. Court Place
(If rural, give LOCATION)
2.(a) If veteran, name war none

3. (a) FULL NAME

Charles Nohe Fisher

3. (b) Social Security Number

216-03-9084

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Marie T. Fisher

6. (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) January 21, 1890

8. AGE: Year 58 Months 10 Days 28 If less than one day hrs. min.

9. Birthplace Washington, D. C.
(Town, county, and state)

10. Usual occupation bank clerk

11. Industry or business

12. Name Elmer E. Fisher

13. Birthplace Washington, D. C.

14. Maiden name Agnes L. Nohe

15. Birthplace Washington, D. C.

16. Informant Charles O. Fisher

Address Westminster, Md.

17. burial Date thereof 12/22/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. John's Catholic Cem.

Location Westminster, Md.

18. Funeral director J. Francis Reese

Address Westminster, Md.

19. 12/30/48 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19, 1948, at 5:20 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from about Jan. 16, 1948 to Dec. 19, 1948 and that I last saw him alive on Dec. 19, 1948

Immediate cause of death Myocardial Infarction DURATION 11 mo.

Due to

Due to

Other conditions Diabetes (severe) 15 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. B. Birmingdale, M.D. M. D. or other

Address Westminster, Md. Date signed 12/30/48

MARGIN RESERVED FOR BINDING

VS A15 9-45/54

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 28 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 24

12339

1. PLACE OF DEATH:

County Carroll
 City or town Henryton, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 year, 6 months, 26 days
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch
 How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town 17
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 605 N. Mount Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

Dorothea Foster

3. (b) Social Security Number

4. Sex female 5. Color or race col. 6. (a) Single, married, widowed, or divorced single
 B. (b) Name of husband or wife _____
 B. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) October 15, 1926
 8. AGE: Years 22 Months 2 Days 6 It less than one day _____ hr. _____ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation None

11. Industry or business

12. Name Richard Foster13. Birthplace Tennessee, S.C.14. Maiden name Landonia Mathews15. Birthplace Baltimore, Maryland16. Informant DeceasedAddress Burial

17. Date thereof (month) (day) (year)

Cemetery or crematory Mt. Zion CemeteryLocation Maryland18. Funeral director Wm. R. WilliamsAddress 322 N. Schroeder St19. December 21, 1948

(Date rec'd by registrar)

Deputy Local

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH December 21, 1948 at 7:45 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27, 1947 to December 21, 1948and that I last saw her alive on December 21, 1948Immediate cause of death Pulmonary TuberculosisDURATION
June 1941

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Neaken Hoffman, M.D.

M.D. or other

Address Henryton, Maryland Date signed 12-21-48

RECEIVED
DEC 27 1961
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

12340
76

1. PLACE OF DEATH:

County Carroll
City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 yrs
Hospital, institution, or street address where death occurred:
Rear Penna. Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll
City or town Rural Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rear Penna. Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Lucretia Ann Fowble

3. (b) Social Security Number

none

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Le-Roy Fowble6. (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.)

May 1, 1880

8. AGE:

Years 68Months 7Days 19

If less than one day

hrs. min.

9. Birthplace

Frd. Co. Md.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

not known

13. Birthplace

" "

14. Maiden name

Alice Shane

15. Birthplace

Frd. Co. Md.

16. Informant

Le-Roy Fowble

Address

Rr. Penna. Ave. Westminster

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

Dec 22, 1948
(month) (day) (year)

Cemetery or crematory

Meadowbrook Cemetery

Location

Farmy Lane Rd. Westminster, Md.

18. Funeral director

H. Bassford Son

Address

Westminster, Md.

19.

12/21 19 48
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20, 1948 at 6:00 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 5, 1948 to Dec 20, 1948 and that I last saw her dead alive on December 20, 1948

Immediate cause of death

CoronaryocclusionArterio-sclerosisGeneralDue toHypertensionmyocardialdegenerationValvular5 yrsDue toInsufficiencyRegimentalDecompensationOther conditionsCerebral Hemorrhage OctLeft Hemiplegia (Partial) 1945
(Include pregnancy within 3 months of death)Major findings of operationsDate of op.Autopsy resultsPHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William SpeicherWestminster, Md.

Address

M. D. or other

Date signed 12/20/48

Date signed

Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 7H

1. PLACE OF DEATH: Carroll
County Sykesville
City or town (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year, 1 month, 7 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 1 year, 1 month, 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Frederick
City or town Sabillasville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME Florence Belle Fox 3. (b) Social Security Number _____

4. Sex female 5. Color or race white 8. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Charles R. Fox

7. Birth date of deceased (mo., day, yr.) 8-28-1877 5. (c) If alive, give age unknown years

8. AGE: Years 71 Months 3 Days 27 If less than one day _____ hrs. _____ min.

9. Birthplace Washington County, Maryland
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business _____

FATHER 12. Name Upton Brown
13. Birthplace Washington County, Maryland

MOTHER 14. Maiden name Margaret Himes
15. Birthplace Washington County, Maryland

18. Informant Hospital records

Address Springfield State Hospital

17. Burial Date thereof 12-28-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bethel Cem.

Location Sherrmont, Md.

18. Funeral director M. L. Creager & Son

Address Sherrmont Md.

19. Dec. 25 1948 C. Henry Wren Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 25, 19 48 at 12.00 noon

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 3, 19 48 to December 25 19 48
and that I last saw h. er alive on December 25, 19 48

Immediate cause of death Chronic myocarditis and myocardial degeneration (at least) DURATION 1 year

Due to Generalized arteriosclerosis about 3 years

Due to _____

Other conditions Psychosis with cerebral arteriosclerosis about 3 years

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Manner of injury _____ Injured at work? _____

23. SIGNATURE Gene L. Hitchman M.D.

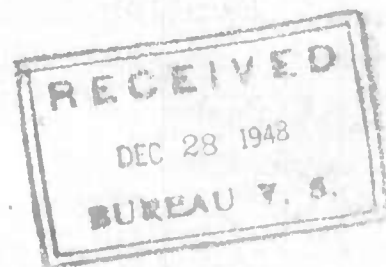
December 25, 1948, Springfield State Hosp
Address _____ Date signed _____

MARGIN RESERVED FOR BINDING

9-45-154

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll
City or town Supersville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs 7 mo 13 da
Hospital, institution, or street address where death occurred Springfield State Hospital
How long in hospital or institution 4 yrs 7 mo 13 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3500 Park Heights Ave
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Anna Dora Glassner

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Jan 15 - 1868

8. AGE: 79 Years 11 Months 13 Days hrs. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Simon Goldman

12. Name Simon Goldman

13. Birthplace Russia

14. Maiden name Dora Goldman

15. Birthplace Russia

16. Information Mitchell Glassner

Address 3500 Park Heights Ave

17. Burial, cremation, or removal, Which Burial Date thereof 12-27-48
(month) (day) (year)

Cemetery or crematorium Bethel Hebrew

Location Belair Road

18. Funeral director Jack Reuss, Inc

Address 2100 Entaw Place

19. Dec. 26 1948 C. Harry Weir
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 26 1948 at 10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13 1948 to Dec 26 1948 and that I last saw him alive on Dec 26 1948

Immediate cause of death Chc. Myocarditis DURATION 4 yrs

Due to Chc. Myocarditis 5 yrs

Other conditions Shunt Arterio Sclerosis 3 yrs

Diabetes 3 yrs

Surgens of foot 2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. J. Gustafson M.D.

Address Supersville Ind Date signed 12/26/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 28 1948

BUREAU F. B. I.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll
 City or town Henryton, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 years, 3 mos., 27 days
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
 How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore -1-
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1109 Pennsylvania Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____ ✓

3. (a) FULL NAME

WILLIAM WESTLEY GREEN

3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife _____
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) August 4, 1888
 8. AGE: Years 60 Months 4 Days 26 If less than one day _____ hrs. _____ min.

9. Birthplace New York City
 (Town, county, and state)
 10. Usual occupation Cook
 11. Industry or business _____
 12. Name John Green
 13. Birthplace Georgia
 14. Maiden name Julia Carter
 15. Birthplace Pennsylvania

16. Informant Deceased
 Address _____
 17. Removal Date thereof 1/1/1949
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory City Marquee
 Location Baltimore, Maryland
 18. Funeral director Mrs. Samuel T. Hemmley
 Address 578 W Biddle St
 19. Dec. 30, 48 Albert R. Smith
 (Date rec'd by registrar) (year) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30, 19 48, at 5: A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 30, 19 48, to Dec. 30, 19 48
 and that I last saw him alive on December 30, 19 48

Immediate cause of death Pulmonary Tuberculosis

DURATION
Aug.
1945

Due to _____
 Due to _____
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Heaven Hoffman, M.D. M. D. or other _____
 Address Henryton, Md. Date signed 12-30-48

REPORT TO THE SECRETARY OF THE ARMY

REPORT TO THE SECRETARY OF THE ARMY

REPORT TO THE SECRETARY OF THE ARMY

REPORT TO THE SECRETARY OF THE ARMY

RECEIVED

JAN 4 1949

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12344

Reg. Dist. No. 81

1. PLACE OF DEATH

County CarrollCity or town Union Bridge
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County CarrollCity or town Union Bridge
(If outside city or town limits, write RURAL and give nearest town)Street No. Rural
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William Henry Groves

3. (b) Social Security Number

705-10-2087

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Helen Reinhart Grove

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Aug. 25-1895

8. AGE:

Years

Months

Days

If less than one day

53327

hrs.

min.

9. Birthplace

Baltimore, Md.
(Town, county and state)

10. Usual occupation

Tool maker

11. Industry or business

None

12. Name

Lewis R. Groves

13. Birthplace

Maryland

14. Maiden name

Cora M. Hippen

15. Birthplace

Maryland

16. Informant

Helen R. Groves

Address

Union Bridge, Md. R. Hl.

17. (Burial, cremation, or removal) Which?

Burial

Date thereof

12/24/48
(month) (day) (year)

Cemetery or crematorium

Deer Creek Cemetery

Location

Daughton Road

18. Funeral director

H. D. Hartzler & Sons

Address

Union Bridge & New Windsor, Md.

19. (Date rec'd by registrar)

Dec 23, 1948

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22 1948 at 10:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him alive on

19

Immediate cause of death

Coronary artery disease

CAUSATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James T. March, Deputy Medical Examiner

M. D. or other

Address

Wheaton, Md.Date signed 12-22-48

RECEIVED

DEC 27 1948

BUREAU V. G.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12345

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll
 City or town Westminster
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 50 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll
 City or town Westminster
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 182 West Main St.
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Wilmer A. Haines

3. (b) Social Security Number

none

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white married6. (b) Name of husband or wife Ellen R. Haines6. (c) If alive, give age 74 years7. Birth date of deceased (mo., day, yr.) October 1, 18698. AGE: Years 79 Months 2 Days 11 If less than one day
..... hrs. min.9. Birthplace Pennsylvania
(Town, county, and state)10. Usual occupation Labor--City trucks

11. Industry or business

12. Name Andrew Haines13. Birthplace Penna.14. Maiden name Katherine Trumine15. Birthplace Maryland16. Informant Mrs. W. A. HainesAddress Westminster, Md.17. burial Date thereof 12/15/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetary or crematory Meadow Branch CemeteryLocation near Westminster, Md.18. Funeral director J. Francis ReeseAddress Westminster, Md.19. 12/14 48 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12 48, at 10:50 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 26 48 to Dec 12 48
and that I last saw him alive on Dec 11 48Immediate cause of death peritonitis with
infarction

DURATION

46 daysDue to diabetes mellitus 8 yearsDue to arterio-sclerosis 5 yrs

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Phap R. Fout MD

M.D. or other

Address Westminster, Md. Date signed 12-13-48

RECEIVED

DEC 16 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

12346

1. PLACE OF DEATH:

County CARROLL
 City or town SYKESVILLE
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 months, 28 days
 Hospital, institution, or street address where death occurred:
Springfield State Hospital
 How long in hospital or institution? 2 months, 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Prince George's
 City or town Bladensburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 13 Bryant Avenue
 (If rural, give LOCATION)
 2. (a) If veteran, name war ✓

3. (a) FULL NAME

CATHERINE COX HARRIS

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced SINGLE
 6. (b) Name of husband or wife _____
 7. Birth date of deceased (mo., day, yr.) 5/28/21 8. (c) If alive, give age _____ years
 8. AGE: Years 27 Months 6 Days 17 It less than one day _____ hrs. _____ min.

9. Birthplace Washington, D. C.
 (Town, county, and state)

10. Usual occupation None

11. Industry or business _____

12. Name George Harris

13. Birthplace Virginia

14. Maiden name Margaret Cox

15. Birthplace Virginia

16. Informant Record, Springfield State Hospital

Address Sykesville, Maryland

17. Burial Date thereof Dec. 19, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Luke's Cemetery

Location Chesapeake, Maryland

18. Funeral director J. Daniels, Inc.

Address Annapolis, Maryland

19. Dec 16, 1948 Registrar Chas. H. Keen
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15 19 48 at 1:45 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 17 19 48 to December 15 19 48
 and that I last saw h. 34 alive on December 15 19 48

Immediate cause of death _____

Pulmonary Tuberculosis

DURATION
Known
3 mos.

Due to _____

Due to _____

Other conditions Schizophrenia, catatonic 10 yrs.

_____ type

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Manner of injury _____ Injured at work? _____

23. SIGNATURE Joseph H. Marshall, M.D.

Address Sykesville, Maryland Date signed 12/15/48

M. D. or other



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1315 12347 76

1. PLACE OF DEATH:

County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 198 E. Main St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Mabel Blanche Harris

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Single

8.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Feb 21 - 1880 6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day
68 hrs. min.

9. Birthplace Henderson, N.C.
(Town, county, and state)

10. Usual occupation College Teacher

11. Industry or business

12. Name Samuel R. Harris

13. Birthplace Henderson, N.C.

14. Maiden name Rosalie Hicks

15. Birthplace Henderson

16. Informant James H. Pyle

Address Southbrook Park

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/24/48
(month) (day) (year)

Cemetery or crematory Elmwood

Location Henderson, North Carolina

19. Funeral director Frank H. Newell

Address Pikeville, Maryland

19. Dec 21 19 48 A. W. H. H. H.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-21-48 at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 10 - 19 48 to Dec 21 19 48

and that I last saw him/her alive on Dec 21 19 48

Immediate cause of death Myocarditis (acute) DURATION

24 hrs.

Due to

Due to Unknown

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE W. C. Jernstedt

Address Westminster Md M. P. or other

Date signed 12-21-48

MARGIN RESERVED FOR BINDING

VS 415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

12348

1. PLACE OF DEATH:

County... CassellCity or town... Lykensville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

Now long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MD County... CassellCity or town... Lykensville
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Marion Edward Hipsley

3. (b) Social Security Number

213-03-2080

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Myrtle Condon

6. (c) If alive, give age... years

7. Birth date of

deceased (mo., day, yr.)

October 3, 1885

8. AGE:

Years

Months

Days

If less than one day

63128

hrs.

min.

9. Birthplace

Ellistown, Md
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

FATHER

12. Name

John A. Hipsley

13. Birthplace

Md.

MOTHER

14. Maiden name

Jane Jones

15. Birthplace

Md.

16. Informant

Mrs Myrtle Hipsley

Address

Lykensville, Md

17.

(Burial, cremation, or removal, Which?)

Date thereof

12-3-48
(month) (day) (year)

Cemetery or crematory

Springfield

Location

Lykensville, Md

18. Funeral director

C. Harry Wren

Address

Lykensville, Md

19.

(Date rec'd by registrar)

Dec 248C. Harry Wren

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... December 1st 1948 at 12:15 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 27 1948 to Dec. 1st 1948and that I last saw him alive on Nov. 27 1948

Immediate cause of death

Tuberculosis of Lung

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

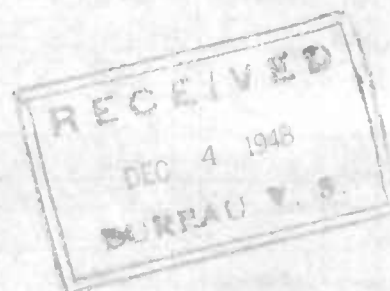
Injured at work?

23. SIGNATURE

Dr. C. Martin
Pandalltown, Md

M. D. or other

Date signed 12/1/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

12349

74

1. PLACE OF DEATH: <i>Carroll</i> County..... City or town..... <i>Rural - Sykesville</i> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <i>4 days</i> Hospital, institution, or street address where death occurred: <i>Springfield State Hospital</i> How long in hospital or institution?..... <i>4 days</i>			2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <i>Maryland</i> County..... City or town..... <i>Baltimore</i> (If outside city or town limits, write RURAL and give nearest town) Street No. <i>2661 W. North Ave.</i> (If rural, give LOCATION) 2. (a) If veteran, name war..... <input checked="" type="checkbox"/>		
3. (a) FULL NAME <i>Frederick Rowland Hudgins</i> (Frederick Rowland Hudgins)			3. (b) Social Security Number <i>215-01-5285A</i>		
4. Sex <i>M</i>	5. Color or race <i>W</i>	6. (a) Single, married, widowed, or divorced <i>Widower</i>	MEDICAL CERTIFICATION		
6. (b) Name of husband or wife <i>Anne Johnson Hudgins</i>			20. DATE OF DEATH <i>Dec. 19, 1948</i> at <i>1:55 A.M.</i>		
7. Birth date of deceased (mo., day, yr.) <i>July 14, 1874</i>			21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <i>Dec. 15, 1948</i> to <i>Dec. 19, 1948</i> and that I last saw him alive on <i>Dec. 18, 1948</i>		
8. AGE: Years <i>74</i> Months <i>5</i> Days <i>5</i> If less than one day..... hrs. min.			Immediate cause of death <i>Generalized arteriosclerosis</i> <i>Myocardial degeneration</i> <i>terminal bronchopneumonia</i>		
9. Birthplace <i>Baltimore, Md.</i> (Town, county, and state)			DURATION <i>3</i> <i>2</i>		
10. Usual occupation <i>Clerk - retired</i>			Due to <i>terminal bronchopneumonia</i>		
11. Industry or business <i>Enterprise Fuel Co.</i>			Due to <i>Senile psychosis</i>		
FATHER 12. Name <i>Edward C. Hudgins</i>			Other conditions <i>Senile psychosis</i> (Include pregnancy within 3 months of death)		
13. Birthplace <i>Va.</i>			Major findings of operations Date of op.		
MOTHER 14. Maiden name <i>Annie J. Robinson</i>			Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.		
15. Birthplace <i>Balto., Md.</i>			22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of Where did injury occur?..... (City or town)..... (County)..... (State)..... Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?.....		
16. Informant <i>Mr. Alvin Hudgins</i> Address <i>2661 W. North Ave.</i>			23. SIGNATURE <i>Joseph H. Marshall, M.D.</i> M.D. or other Address <i>Springfield State Hospital</i> Date signed <i>12/19/48</i>		
17. Burial (Burial, cremation, or removal. Which?) Date thereof <i>12/21/48</i> (month) (day) (year) Cemetery or crematory..... <i>Greenmount Cem.</i> Location..... <i>Balto., Md.</i> 18. Funeral director <i>WM. J. TICKNER & SONS</i> Address <i>Balto., Md.</i>			19. Date rec'd by registrar <i>Dec 20 48</i> <i>A.W. Hedrick</i> Registrar		

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll
City or town Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months 2 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County _____
City or town Baltimore 30
(If outside city or town limits, write RURAL and give nearest town)
Street No. 309 S. Sharp Street
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Jacob Cornelius Ingliss Sr.

3. (b) Social Security Number

220-07-4394

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Widowed

8. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) May 29, 1898 8. (c) If alive, give age _____ years

8. AGE: Years 50 Months 6 Days 4 It less than one day _____ hrs. _____ min.

9. Birthplace Georgetown, S. Carolina
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business _____

12. Name Joseph Ingliss

13. Birthplace South Carolina

14. Maiden name Elizabeth Jones

15. Birthplace South Carolina

16. Informant Patient

Address _____

17. Removal Date thereof Dec 4, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baltimore City morgue

Location Baltimore City

18. Funeral director Mrs Samuel T. Hensley

Address 578 W. Biddle Street

19. December 3, 1948 Albert R. Swank Deputy Local Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3, 1948, at 7:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1948, to December 3, 1948

and that I last saw him alive on December 3, 1948

Immediate cause of death Pulmonary Tuberculosis DURATION November 1942

Duo to _____

Duo to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

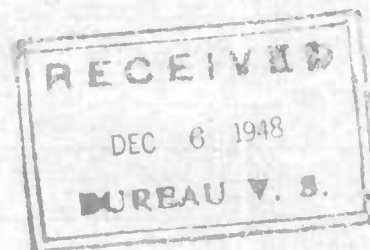
23. SIGNATURE Reuben Hoffman, M.D. M. D. or other _____

Address Henryton, Maryland Date signed Dec. 3, 1948

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 71

1. PLACE OF DEATH:

County Carroll
 City or town Rural, Westminster, R. D. 2
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
Westminster District
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Carroll
 City or town Rural, Westminster, R. D. 2
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Westminster District
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Joseph Clinton Kemper

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Esta (Humbert) Kemper
 8. (c) If alive, give age 60 years
 7. Birth date of deceased (mo., day, yr.) March 23 1887
 8. AGE: Years 61 Months 9 Days 6 If less than one day
hrs.min.

9. Birthplace Carroll County, Md.
 (Town, county, and state)
 10. Usual occupation Farming
 11. Industry or business Farm
 FATHER
 12. Name David L. Kemper
 13. Birthplace Carroll County, Md.
 MOTHER
 14. Maiden name Scenora Myers
 15. Birthplace Carroll County, Md.

16. Informant Carroll G. Kemper
 Address Penna. Avenue., Westminster, Md.
 17. Burial Date thereof 1/1/49
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory St. Marys Union Cemetery
 Location Silver Run, Md.
 18. Funeral director J. W. Little & Son, P. O. Little
 Address Littlestown, Pa.
 13. P. J. Little 19. J. C. Little
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29 19 48 at 4:05 P
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Oct 1 19 48 to Dec 29 19 48
 and that I last saw him alive on Dec 29 19 48

Immediate cause of death
Myocarditis (ch)
Hypertension (auth)
 DURATION
 Due to
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations None Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide None Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE W. C. Jernette md. M. D. or other
Westminster Md 12-30-48
 Address Date signed

MARGIN RESERVED FOR BINDING

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 3 1949

BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH.

Reg. Dist. No. 74

12352

1. PLACE OF DEATH:

County Carroll
 City or town Luskville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? since may 6. 1944.
 Hospital, institution, or street address where death occurred:
Springfield St. Hosp.
 How long in hospital or institution? 4 years 7 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Baltimore, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 819 North Washington Sts.
 (If rural, give LOCATION)
 2.(a) If veteran, name war ☒

3. (a) FULL NAME

Janet Klimm JANET KLIMM.

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced —
 8. (b) Name of husband or wife George Klimm
 7. Birth date of deceased (mo., day, yr.) OCT. 7 - 1880 6. (c) If alive, give age 7 years
 8. AGE: Year 68 Month 2 Day 1 If less than one day hrs. min.

9. Birthplace Baltimore Md.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business —
 12. Name Patrick Craghan
 13. Birthplace Ireland
 14. Maiden name Elizabeth O'Connor
 15. Birthplace Ireland

16. Informant son Jerome Klimm
 Address 819 North Washington Sts. Baltimore
 17. Removal-BURIAL Date thereof Dec. 18, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or chapel St Vincent
 Location 1217 St Paul St. Balto. Md.
 18. Funeral director William Cross Inc.
 Address 1217 St Paul St. Balto. Md.
 19. Dec. 19 48 Chas. H. H.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18 1948 at 6 30 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1947 to Dec. 17 1948
 and that I last saw him er. alive on Dec. 17 1948

Immediate cause of death heart decompensation DURATION
 Due to arteriosclerosis, hypertension
270/140, myocardial infarcts.
 Due to —
 Other conditions Demencia praecox
hebephrenic type
 (Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide — Date of —
 Where did injury occur? — (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) —
 Means of injury — Injured at work? —

23. SIGNATURE Elizabeth A. Winney M.D. M. D. or other —
 Address Springfield St. H. Date signed Dec. 18 48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 12553

1. PLACE OF DEATH:

County CarrollCity or town Westminster
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 yrs.Hospital, institution, or street address where death occurred:
234 E. Main

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County CarrollCity or town Westminster
(If outside city or town limits, write RURAL and give nearest town)Street No. 234 E. Main St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Esther Romaine Koontz

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Maurice Koontz

7. Birth date of deceased (mo., day, yr.)

Oct 23rd 19056. (c) If alive, give age 40 years

8. AGE:

Years 43

Months

2

Days

6

It less than one day

hrs. min.

9. Birthplace

Carroll

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Maurice KoontzAddress 423 E. Main St. Westminster

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Dec 31st 1948
(month) (day) (year)

Cemetery or crematory

Westminster Cemetery

Location

Westminster Md.

18. Funeral director

H. Bankard & Son

Address

234 E. Main St. Westminster

19. (Date rec'd by registrar)

Jan 30 1949

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28 1948 at 8:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 12 - 1948 to Dec 28, 1948and that I last saw her alive on Dec. 26 - 1948Immediate cause of death Coronary Arteriosclerosis

DURATION

a few minutesDue to myocarditis7 mks

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Chas R. Fouts MD

M. D. or other

Address Westminster Md.Date signed 12 30 48

MARGIN RESERVED FOR BINDING

VS A15 9-45-1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 3 1949

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

12354

72

1. PLACE OF DEATH:

County Carroll
 City or town Sykesville, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? since Dec. 3, 1923
 Hospital, institution, or street address where death occurred:
Springfield State Hospital
 How long in hospital or institution? Dec. 3, 1923

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Carroll
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1
 (If rural, give LOCATION)
 2. (a) If veteran, name war. ✓

3. (a) FULL NAME

H
WILLIAM LANCASTER

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

/

7. Birth date of deceased (mo., day, yr.)

1886

6. (c) If alive, give age years

8. AGE:

62

Years

Months

?

Days

?

If less than one day

hrs.

min.

9. Birthplace

Baltimore City
 (Town, county, and state)
Painter

10. Usual occupation

11. Industry or business

/

FATHER

12. Name Benjamin Lancaster13. Birthplace Baltimore

MOTHER

14. Maiden name Caroline Smith15. Birthplace Baltimore16. Informant Springfield State HospitalAddress Sykesville, Maryland

17. Burial

(Burial, cremation, or removal. Where?)

Date thereof Dec 11/48
(month) (day) (year)

Cemetery or crematory

Baldwin
Baltimore

Location

18. Funeral director

Address 2014 Orleans St

19. Date rec'd by registrar

Dec 10 19 48

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-9-1948 19 48 at 5:55 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1, 1947 19 47 to 12-9- 19 48and that I last saw him alive on 12-9-49 19 49

Immediate cause of death

heart failure and chronic myocarditisDue to advanced pulmonary tuberculosis

Due to cerebral arteriosclerosis
dementia praecox, hebephrenic

Other conditions Healed rickets

(Include pregnancy within 3 months of death)

Major findings of operations

/

Date of op. /

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide / Date of /Where did injury occur? / (City or town) (County) (State)Injured at home, farm, industry, public place (where?) /Means of injury / Injured at work? /

23. SIGNATURE

Marion Swartz, M.D.
 M.D. or other

Address Springfield State Hospital Date signed /

DURATION

2 yrs9 yrs25 yrs

Evidence for change of
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12355

FILM No. G 118 JAN 7 1949 CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH:

County.....**Carroll**
City or town.....**Westminster (rural)**
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....**8 days**

Hospital, institution, or street address where death occurred:
Carroll County Home

How long in hospital or institution?.....**8 days**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....**Maryland** County.....**Carroll**

City or town.....**rural Westminster**
(If outside city or town limits, write RURAL and give nearest town)

Street No.....
(If rural, give LOCATION)

2. (a) If veteran, name war.....**none**

3. (a) FULL NAME

Daniel Reese Lawton

3. (b) Social Security Number

none

4. Sex.....**male** 5. Color or race.....**white** 6. (a) Single, married, widowed, or divorced.....**single**

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....**March 22, 1864** 6. (c) If alive, give age..... years

8. AGE: Years.....**84** Months.....**9** Days.....**6** If less than one day..... hrs. min.

9. Birthplace.....**Philadelphia, Penna.**
(Town, county, and state)

10. Usual occupation.....**labor**

11. Industry or business.....

12. Name.....**Unknown**

13. Birthplace.....**"**

14. Maiden name.....**"**

15. Birthplace.....**"**

16. Informant.....**County Welfare Board**

Address.....**Westminster, Md.**

17. **burial** Date thereof.....**12/29/48**
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....**County Home Cemetery**

Location.....**Westminster, Md.**

18. Funeral director.....**J. Francis Reese**

Address.....**Westminster, Md.**

19. (Date rec'd by registrar).....**12/28** 19. **J. F. Reese** Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....**December 28, 1948** at.....**1 A.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
12-20-48 to **12-28-48**
and that I last saw him alive on **12-27-48**

Immediate cause of death.....**Coronary thrombosis** DURATION.....**8 days**

Due to.....**Coronary thrombosis** DURATION.....**8 days**

Due to.....**Coronary thrombosis** DURATION.....**8 days**

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....**NO** Date of op.....

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur.....**NO** (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....**J. F. Reese** M. D. or other

Address.....**Westminster, Md.** Date signed.....**12-28-48**

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 31 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

12356

76

1. PLACE OF DEATH:

County Carroll
City or town Westminster, Md. Route 4
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster, Md. (Reese)
(If outside city or town limits, write RURAL and give nearest town)
Street No. Route 4
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Ella M. Little

3. (b) Social Security Number

none

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed

8.(b) Name of husband or wife Lewis J. Little

7. Birth date of deceased (mo., day, yr.) July 16, 1864 B.(c) If alive, give age

8. AGE: Years 84 Months 4 Days 24 If less than one day

9. Birthplace Carroll County, Md.
(Town, county, and state)

10. Usual occupation none

11. Industry or business

12. Name Samuel Hughes

13. Birthplace Maryland

14. Maiden name Sarah Lockard

15. Birthplace Maryland

16. Informant Mrs. Edgar Ward

Address Westminster, Md. R 4.

17. burial Date thereof 12/13/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Deer Park Cemetery

Location Smallwood, Md.

18. Funeral director J. Francis Reese

Address Westminster, Md.

19. 12/11 48 Edward Ward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 10, 1948 at 9:12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased Apr 8 - 1948 to Dec 10 1948
and that I last saw him alive on Dec 9 - 1948

Immediate cause of death acute cardiac decompensation DURATION 20 hrs

Due to Chronic myocarditis 3 yrs

Due to Arteriosclerosis 5 yrs

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE Chas R. Fouty, M.D.

Address Westminster, Md. Date signed 12-10-48

MARGIN RESERVED FOR BINDING

I

9.45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 14 1948

BUREAU V. C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County CarrollCity or town Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 26 daysHospital, institution, or street address where death occurred:
Maryland Tuberculosis SanatoriumHow long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore 1
(If outside city or town limits, write RURAL and give nearest town)Street No. 1105 Brewer Street
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Leonard Mack

3. (b) Social Security Number

217-05-3608

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

maleCol.Married8. (b) Name of husband or wife Thelma Mack6. (c) If alive, give age 30 years7. Birth date of deceased (mo., day, yr.) April 16, 19038. AGE: Year 45 Month 8 Days 11 If less than one day
..... hrs. min.9. Birthplace Charlotte County, Va.
(Town, county, and state)10. Usual occupation Laborer

11. Industry or business

12. Name Silas Mack13. Birthplace Virginia14. Maiden name Mandy Carter15. Birthplace Virginia16. Informant Deceased

Address

17. Buried Date thereof Dec 30/1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Mary'sLocation St. Mary's18. Funeral director St. Mary's

Address

19. December 27, 1948
(Date rec'd by registrar) Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26, 1948 at 11:55 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
November 30, 1948 to December 26, 1948and that I last saw him alive on December 26, 1948

Immediate cause of death

Pulmonary Tuberculosis

DURATION

Sept.1948

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Richard Hoffman, M.D.

M. D. or other

Address Henryton, Maryland Date signed 12-27-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Carroll
 City or town Union Bridge Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Back Hill
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)
 State Maryland County Carroll
 City or town Union Bridge - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Back Hill
 (If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

William Tell Matthews

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Martha E. Matthews

7. Birth date of deceased (mo., day, yr.)

Dec. 4 - 1973

6. (c) If alive, give age years

8. AGE:

Years 75 Months 0 Days 11
 It less than one day hrs. min.

9. Birthplace

Romney, W. Va.
(Town, county, and state)

10. Usual occupation

Retired - School Teacher

11. Industry or business

Teacher

12. Name

Daniel Matthews

13. Birthplace

W. Va.

14. Maiden name

Harriet Jackson

15. Birthplace

W. Va.

16. Informant

Mrs. Martha E. Matthews

Address

Union Bridge, R. W. Md.

17. (Burial, cremation, or removal, which?)

Burial

Date thereof (month) (day) (year)

12-18-48

Cemetery or crematory

Int. by Cemetery

Location

Union Bridge, Md.

18. Funeral director

Ch. H. Hartley & Sons

Address

Union Bridge & New Windsor, Md.

19. (Date rec'd by registrar)

12/17/48

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15 1948 at 10:15 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 6 1946, to Dec 15 1948and that I last saw him alive on Dec 15 - 48 1948

Immediate cause of death

multiple Atherosclerosis
general neurones

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

J. H. Legg M. D. or otherAddress Union Bridge Date signed 12-16-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County CarrollCity or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 12 daysHospital, institution, or street address where death occurred:
Springfield State HospitalHow long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarrollCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 103 S. Arlington Avenue
(If rural, give LOCATION)2.(a) If veteran, name war ☒

3.(a) FULL NAME

WALTER MAXWELL

3.(b) Social Security Number

4. Sex <u>M</u>	5. Color or race <u>W</u>	6.(a) Single, married, widowed, or divorced <u>Single</u>
--------------------	------------------------------	--

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) January 19, 1883
8.(c) If alive, give age _____ years

8. AGE: Years <u>65</u>	Months <u>11</u>	Days <u>4</u>	If less than one day _____ hrs. _____ min.
----------------------------	---------------------	------------------	---

9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Boiler Maker

11. Industry or business

12. Name James Maxwell13. Birthplace Baltimore14. Maiden name Seveter Harvey15. Birthplace Baltimore16. Informant Record, Springfield State HospitalAddress Sykesville, Maryland17. Burial Date thereof 12-24-48
(Burial, cremation, or removal) (month) (day) (year)Cemetery or crematory St. John'sLocation York Rd. Balto. Ind.18. Funeral director Fredrick A. ColeAddress 1200 Lombard St.19. Dec. 29 19 48 C. Harry Wew
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22 19 48 at 6:20 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
December 11 19 48 to December 22 19 48and that I last saw him alive on December 22 19 48

Immediate cause of death <u>Cerebral Hemorrhage</u> <u>Bronchopneumonia</u>	DURATION <u>Dec. 20</u> <u>3 days</u>
---	---

Due to

Due to

Other conditions <u>Pulmonary tuberculosis, left lung & Schizophrenia,</u> (include pregnancy within 3 months of death)	<u>Nov. 1, 48</u> <u>1917</u>
---	----------------------------------

Major findings of operations

Autopsy results <u>Partial autopsy: Results as above.</u>	Date of op. <u>Head not opened.</u>
--	--

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE M. Virginia Beyer M.D.
M. D. or otherAddress Sykesville, Maryland Date signed 12/23/48

RECEIVED

DEC 28 1945

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 12360 24

1. PLACE OF DEATH:

County CarrollCity or town Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 month, 3 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis SanatoriumHow long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____City or town Baltimore 1
(If outside city or town limits, write RURAL and give nearest town)Street No. 629 Gilmore Street
(If rural, give LOCATION)2. (a) If veteran, name war _____ ☒

3. (a) FULL NAME

Catherine McAllister

3. (b) Social Security Number

212-22-6255

4. Sex

female

5. Color or race

Col.

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Joseph McAllister

7. Birth date of

deceased (mo., day, yr.) March 2, 19276. (c) If alive, give age 24 years

8. AGE:

Years

Months

Days

If less than one day

21918

hrs.

min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation Domestic

11. Industry or business

MOTHER FATHER

12. Name William Brinkley13. Birthplace Virginia14. Maiden name Mable Abrams15. Birthplace Maryland16. Informant Mable Brinkley (mother)Address 302 N. Poppleton Street17. Burial
(Burial, cremation, or removal. Which?)Date thereof 17 Dec. 1948
(month) (day) (year)Cemetery or crematory WestportLocation Westport18. Funeral director Mrs. Katie R. WilliamsAddress 322 N. Scholfield19. December 20, 1948
(Date rec'd by registrar)Albert R. Swankley
Deputy Local Registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20, 1948 at 9:55 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 17, 1948 to December 20, 1948 and that I last saw her alive on December 20, 1948

Immediate cause of death

Pulmonary Tuberculosis

DURATION

March 1948

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Nealen Hoffman, M.D.
M. D. or otherAddress Henryton, Maryland Date signed 12-20-48

RECEIVED BY THE UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED BY THE UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED BY THE UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED BY THE UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED BY THE UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED

DEC 22 1913

BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:

County Carroll
 City or town Henryton, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 months
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
 How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County
 City or town Baltimore 1
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1056 Pennsylvania Avenue
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Jean McCallum

3. (b) Social Security Number

4. Sex Female 5. Color or race Col. 9.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Jerry McCallum
 8.(c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) February 19, 1923
 8. AGE: Years 25 Months 9 Days 21 If less than one day hrs. min.
 9. Birthplace Wilmington, N. Carolina
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business
 12. Name Matthews Johnson
 13. Birthplace N. Carolina
 14. Maiden name Eugene (unknown)
 15. Birthplace N. Carolina
 16. Informant Deceased

Address

17. Burial Date thereof Dec. 12, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory
 Location Clarkston, S. Carolina
 18. Funeral director Mrs. Samuel H. Hensley
 Address 578 W. Biddle St
 19. December 9, 1948 Albert R. Swannham
 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9, 1948 at 8:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 9, 1948 to December 9, 1948
 and that I last saw her alive on December 9, 1948

Immediate cause of death Pulmonary Tuberculosis DURATION April 1948

Due to Due to Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op. Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE Neuben Hoffman, M.D. M. D. or otherAddress Henryton, Maryland Date signed 12-9-48

STATION TO THE UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED BY STATION

STATION TO THE UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED

DEC 11 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 144

1. PLACE OF DEATH:

County CarrollCity or town Detour
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 50yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County CarrollCity or town Detour
(If outside city or town limits, write RURAL and give nearest town)Street No. 18 (Rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

William Cornelius Miller

3. (b) Social Security Number

no

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleWhiteMarried6. (b) Name of husband or wife Clara B. Smith6. (c) If alive, give age 72 years7. Birth date of deceased (mo., day, yr.) Nov. 22. 18728. AGE: Years Months Days If less than one day
76 0 19hrs.min.9. Birthplace Rocky Ridge Fredk Co. Md
(Town, county, and state)10. Usual occupation Retired11. Industry or business Bridge Foreman W.M.R.W. Co12. Name Unknown13. Birthplace Unknown14. Maiden name Unknown Six15. Birthplace Unknown16. Informant Mrs. Clara B. MillerAddress Detour. MD17. Burial Date thereof Dec. 20th 48
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Haughs CemeteryLocation Near Ladiesburg. MD18. Funeral director M. L. Creager & Son.Address Thurmont. MD.19. Dec. 13 1948 Blanche S. Epler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11th. 1948 at 11:30 A:M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 15 1947 to December 11 1948 and that I last saw him alive on December 10 1948

Immediate cause of death

DURATION

chronic myocarditis ?

Due to

Due to

Due to

Due to

Due to

Other conditions Diabetes mellitus ?arterio-sclerosis ?

(Include pregnancy within 3 months of death)

Major findings of operations noneAutopsy results not done Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. Franklin Birch P. D. or otherAddress Thurmont Md. Date signed 12/12/48

MARGIN RESERVED FOR BINDING

I

9.45-15W

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 18 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

12363

1. PLACE OF DEATH:

County CarrollCity or town Henryton, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 year, 4 months, 10 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis SanatoriumHow long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore 17
(If outside city or town limits, write RURAL and give nearest town)Street No. 1112 Fremont Avenue
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Harry Spencer Myers Sr.

3. (b) Social Security Number

213-16-0736

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

malecol.Widow

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 13, 18958. AGE: Years Months Days If less than one day
53 4 8 hrs. min.9. Birthplace Pine Orchard, Maryland
(Town, county, and state)10. Usual occupation Laborer

11. Industry or business

12. Name Charles Henry Myers13. Birthplace Maryland14. Maiden name Elizabeth Johnson15. Birthplace Maryland16. Informant Deceased

Address

17. Buried Date thereof 12 24 1988
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory not CalvaryLocation A A Cemetery18. Funeral director Robert H. H. H.Address 918 E. E. E.19. December 21, 19 48 Albert R. Swank
(Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21, 19 48 7:15 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
August 11, 19 47 to December 21, 19 48and that I last saw him alive on December 21, 19 48Immediate cause of death Pulmonary Tuberculosis

DURATION

Due to Dec. 1941

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Neuber Hoffman, M.D. M. D. or otherAddress Henryton, Maryland Date signed 12-21-48

RECEIVED
DEC 27 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 12364 74

1. PLACE OF DEATH:

County CarrollCity or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Since August 16, 1942

Hospital, institution, or street address where death occurred:

Springfield State HospitalHow long in hospital or institution? Since August 16, 1942

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County ---City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 3249 Chestnut Avenue
(If rural, give LOCATION)2.(a) If veteran, name war --- ✓

3. (a) FULL NAME

NACE, Howard John

3. (b) Social Security Number

4. Sex <u>male</u>	5. Color or race <u>white</u>	6. (a) Single, married, widowed, or divorced <u>married</u>
-----------------------	----------------------------------	--

6. (b) Name of husband or wife Lilly --8. (c) If alive, give age unkn. years7. Birth date of deceased (mo., day, yr.) October 7, 1889

8. AGE:	Years	Months	Days	If less than one day
	<u>59</u>	<u>2</u>	<u>15</u>	<u>hrs. min.</u>

9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Clerk and guard at cottonmill11. Industry or business ---12. Name Jacob Alonze Nace13. Birthplace U.S.14. Maiden name Rachel Beavens15. Birthplace U.S.16. Informant Records of Springfield St. HospitalAddress Sykesville, Maryland17. Burial Date thereof 12-24-48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematorium St Marys (Hampden)Location Baltimore Md18. Funeral director Frank St. SeelyAddress 814 N. 36 St.19. 12/23/48 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22, 1948 at 12:10 p.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1 1947 to December 22, 1948and that I last saw him alive on December 22, 1948Immediate cause of death Bronchopneumonia DURATION 2 daysDue to ---Due to ---Other conditions Schizophrenia, paranoid type 6 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations ---Date of op. ---Autopsy results ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of ---Where did injury occur? --- (City or town) (County) (State)Injured at home, farm, industry, public place (where?) ---Means of injury --- Injured at work? ---23. SIGNATURE Martin Gross, M.D. M. D. or otherAddress Sykesville, Maryland Date signed 12/22/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 12365 159 80

I. PLACE OF DEATH:

County Carroll CoCity or town Taneytown Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Baby 4 1/2 months

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Dec. 28, 1948

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

15 hrs. 15 min.

9. Birthplace

Taneytown, Carroll Co., Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER/FATHER

12. Name

Danell Nelson

13. Birthplace

Greensboro Pa.

14. Maiden name

Nelson M. Hear

15. Birthplace

Beyleville Pa.

16. Informant

Danell Nelson

Address

Taneytown Md

17. (Burial, cremation, or removal, which?)

Date thereof

12-28-48
(month) (day) (year)

Cemetery or crematory

Reformed Episcopal

Location

Taneytown Md.

18. Funeral director

Raymond K. Wright

Address

Union Bridge Md

19. (Date rec'd by registrar)

Dec. 28
(Date rec'd by registrar)

19. 48

Edith M. McKim
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Carroll

City or town

Taneytown
(If outside city or town limits, write RURAL and give nearest town)

Street No.

W. Ballinger St.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

December 28

19. 48

at

6:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 28

19. 48

to Dec. 28

19. 48

and that I last saw him alive on

Dec. 28

19. 48

Immediate cause of death

Respiratory distress

DURATION

Due to

Prematurity, 4 1/2 mos.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

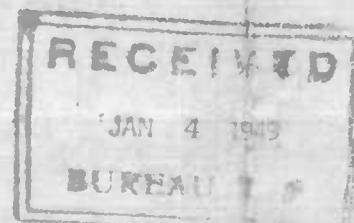
W. Bradley

Address

Taneytown Md

M. D. or other

Date signed 12-28-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County *Capitol Hill*City or town *Springfield*
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *13 yrs 9 mo 23 da*Hospital, institution, or street address where death occurred *Springfield State Hospital*How long in hospital or institution? *13 yrs 9 mo 23 da*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md* County *Montgomery*City or town *Rockville*
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Lester Pollen

3. (b) Social Security Number

4 Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

1902

6. (c) If alive, give age _____ years

8. AGE:

46

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Md.
(Town, county and state)

10. Usual occupation

Laborer

11. Industry or business

12. Name

Highlife Pollen

13. Birthplace

Virginia

14. Maiden name

Anna Reeves

15. Birthplace

Virginia

16. Informant

Highlife Pollen

Address

Rockville Md

17. Burial

Burial

Date thereof

12-31-48

(Burial, cremation, or removal, which?)

(month) (day) (year)

Cemetery or crematory

Greenwood

Location

Wash D.C.

18. Funeral director

W. W. Chambers

Address

3072 - M St. N.W. Wash D.C.

19. Dec 29 1948

C. Harry Wilson

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Dec 29th 1948* at *4-10 A*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 6th 1935 to *Dec 29 1948*and that I last saw him alive on *Dec 29 1948*

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed

RECEIVED

JAN 3 1949

BUREAU T. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12367

Reg. Dist. No. 72

1. PLACE OF DEATH:

County Carroll
 City or town Near Silver Run (Myers District)
 (If outside city or town limits, write RURAL and give nearest town)
20 Years
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Westminster R. D. 2
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Carroll
 City or town Silver Run (Near)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Westminster R. D. 2
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mary Elizabeth Riebling

3. (b) Social Security Number

None

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>	
6. (b) Name of husband or wife <u>Clarence C. Riebling</u>			
8. (c) If alive, give age <u>52</u> years			
7. Birth date of deceased (mo., day, yr.) <u>July 9 1878</u>			
8. AGE:	Years <u>70</u>	Months <u>4</u>	Days <u>26</u>
If less than one day hrs. min.			
9. Birthplace <u>Carroll County, Md.</u> (Town, county, and state)			
10. Usual occupation <u>Housework</u>			
11. Industry or business <u>Housewife</u>			
FATHER	12. Name <u>William Henry Fowler</u>		
	13. Birthplace <u>Carroll County, Md.</u>		
	14. Maiden name <u>Mary Shean</u>		
MOTHER	15. Birthplace <u>Carroll County, Md.</u>		

16. Informant Clarence C. Riebling
 Address Westminster, Md. R. D. 2
 17. Burial Date thereof 12/7/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Mt. Union Cemetery
 Location Near Union Bridge, Md.
 18. Funeral director J. M. Tetterton, Son
 Address Littlestown, Pa. P. O. R. A. Little
 19. Dec. 6th 19 48 Calvin B. Bant
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 5 19 48, at 9 A. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Nov. 23 19 48 to Dec. 5 19 48
 and that I last saw him alive on Dec. 5 19 48

Immediate cause of death Abdominal Carcinomatosis
 DURATION 9 months
 Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE L. L. Potter M.D.
 Address Littlestown, Pa. Date signed 12-6-48

RECEIVED

DEC 8 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 24

12368

1. PLACE OF DEATH:

County Carroll
 City or town Sykesville
 (if outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 29 days
 Hospital, institution, or street address where death occurred:
Springfield State Hospital
 How long in hospital or institution? 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County
 City or town Baltimore
 (if outside city or town limits, write RURAL and give nearest town)
 Street No. Unknown
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

EARL HENRY ROWLAND

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Divorced

8.(b) Name of husband or wife May Glovelia Hess

7. Birth date of deceased (mo., day, yr.) November 21, 1883
 8.(c) If alive, give age years

8. AGE: Years 65 Months 1 Days 5 If less than one day hrs. min.

9. Birthplace Hagerstown, Maryland
 (Town, county, and state)

10. Usual occupation Paper hanger11. Industry or business 12. Name Jonas Rowland13. Birthplace Maryland14. Maiden name Carrie Huyett15. Birthplace Beaver Creek, Maryland16. Informant Record, Springfield State HospitalAddress Sykesville, Maryland

17. Burial Date thereof 12. 20. 48
 (Burial, cremation, or removal) (month) (day) (year)

Cemetery or crematory Rose HillLocation Hagerstown18. Funeral director C. M. Suter & SonsAddress Hagerstown Md.

18. Dec. 27 19 48 C. Henry Zelen
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26 19 48 9:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
November 27 19 48 to December 26 19 48
 and that I last saw him alive on December 26 19 48

Immediate cause of death DURATION

Disease of coronary arteries 11-27-48
(arteriosclerosis)
Hemorrhagic colitis 12-25-48

Due to Other conditions Involuntional Melancholia 4 months

(Include pregnancy within 3 months of death)

Major findings of operations Date of op. Autopsy results Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE M. Virginia Beyer M.D.Address Sykesville, Maryland Date signed 12/26/48

RECEIVED

DEC 30 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12369

Reg. Dist. No. 79

1. PLACE OF DEATH:

County Carroll
 City or town Henryton, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 months, 13 days
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
 How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Caroline
 City or town Greensboro
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (if rural, give LOCATION)
 2. (a) If veteran, name war Yes, World War I ✓

3. (a) FULL NAME

Cordy Roy

3. (b) Social Security Number

217-09-8569

4. Sex Male 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Separated
 6. (b) Name of husband or wife Florence Roy
 7. Birth date of deceased (mo., day, yr.) May 11, 1894 8. (c) If alive, give age 55 years
 8. AGE: Years 54 Months 6 Days 13 If less than one day _____ hrs. _____ min.

9. Birthplace Caroline County, Maryland
(Town, county, and state)10. Usual occupation Laborer

11. Industry or business _____

12. Name Henry Jenkins Roy13. Birthplace Maryland14. Maiden name Harriet Earl15. Birthplace Maryland16. Informant Deceased

Address _____

17. Burial Date thereof 12/11/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory CokersLocation Near Greensboro, Md.18. Funeral director R. B. RawlingsAddress Greensboro, Md.19. December 8, 1948 Alfred R. Smith
(Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 8, 1948, at 5:4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 28, 1948, to December 8, 1948
 and that I last saw him alive on December 8, 1948

Immediate cause of death Pulmonary Tuberculosis
 DURATION Sent 1947

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Neulen S. Brown, M.D. M. D. or otherAddress Henryton, Maryland Date signed 12-8-48

RECEIVED

DEC 9 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH:

County CarrollCity or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? since 6/18/48

Hospital, institution, or street address where death occurred:

Springfield State HospitalHow long in hospital or institution? since 6/18/48

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 907 Wise Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

RUDOLPH, John William

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
<u>male</u>	<u>white</u>	<u>widowed</u>

6.(b) Name of husband or wife Lucy Virginia WilleyDied 12/3/45 6.(c) If alive, give age years7. Birth date of deceased (mo., day, yr.) February 22, 1880

8. AGE:	Years	Months	Days	If less than one day
	<u>68</u>	<u>9</u>	<u>22</u>	hrs. min.

9. Birthplace Shenandoah Co., Virginia
(Town, county, and state)10. Usual occupation Carpenter

11. Industry or business

12. Name Henry Rudolph13. Birthplace Shenandoah Co., Va.14. Maiden name Rebecca Spidler15. Birthplace Shenandoah Co., Va.16. Informant Records of the Springfield St. Hosp.Address Sykesville, Maryland17. Burial Date thereof 12/16/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Maryland ParkLocation Baltimore Md.18. Funeral director Wm. Cook Co.Address 1217 St Paul St19. Dec 14 19 48 Harry Kees
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 14 19 48 at 1:30 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 4 19 48 to Dec. 14 19 48and that I last saw him alive on December 13 19 48

Immediate cause of death	DURATION
<u>Arteriosclerosis</u>	<u>1 yr.</u>
<u>Bronchopneumonia</u>	<u>2 days</u>

Due to

Due to

Other conditions Psychosis with cerebral arteriosclerosis.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Martin Gross, M.D. M. D. or otherAddress Sykesville, Maryland Date signed 12/14/48

RECEIVED

DEC 16 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

12371

93d

76

1. PLACE OF DEATH:

County CarrollCity or town Westminster
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 17 years

Hospital, institution, or street address where death occurred:

243 E. Main

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County CarrollCity or town Westminster
(If outside city or town limits, write RURAL and give nearest town)Street No. 243 E. Main
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Josephine Rupphert

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

—

7. Birth date of deceased (mo., day, yr.)

August 10 - 1875

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

7331

hrs.

min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

FATHER

12. Name

Adam Rupphert

13. Birthplace

Germany

MOTHER

14. Maiden name

Katharine Banger

15. Birthplace

Germany

16. Informant

Katharine Freeman

Address

243 E. Main, Westminster, Md.

17. Burial

BurialDate thereof Dec. 15 - 1948
(month) (day) (year)

(Burial, cremation, or removal, Which?)

Cemetery or crematory

H. John Cemetery

Location

Westminster, Md.

18. Funeral director

H. Bankard Don

Address

Westminster, Md.

19.

12/14/48

1948

H. Bankard Don

Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11 19 48, at 11:30 P.M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 19 48 to Dec 11 19 48and that I last saw her alive on December 11 19 48Immediate cause of death myocardialdegeneration + decompensation 240hypostatic pneumonia Dec 3/48Due to arterio sclerosisseveral

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William Percher

M. D. or other

Address Westminster, Md. Date signed 12/12/48

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-154

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 16 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

12872

76

1. PLACE OF DEATH:

County.....CARROLL
 City or town.....WESTMINSTER
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....LIFE
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....MARYLAND County.....CARROLL
 City or town.....RURAL WESTMINSTER
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....ROUTE 5
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Rickey Murray Rupert

3. (b) Social Security Number

4. Sex.....MALE 5. Color or race.....WHITE 6.(a) Single, married, widowed, or divorced.....SINGLE

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....NOVEMBER 4, 1947 6.(c) If alive, give age..... years

8. AGE: Years.....1 Months.....1 Days.....9 If less than one day..... hrs. min.

9. Birthplace.....CARROLL COUNTY, MD.
 (Town, county, and state)

10. Usual occupation.....NONE

11. Industry or business.....

FATHER 12. Name.....WILLIAM D. RUPPERT
 13. Birthplace.....MD.

MOTHER 14. Maiden name.....FRANCES M. STEW
 15. Birthplace.....MD.

16. Informant.....MRS. W. D. RUPPERT
 Address.....MD.

17. BURIAL Date thereof.....12/15/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Westminster CemeteryLocation.....Westminster, Md.18. Funeral director.....J. Francis ReeseAddress.....Westminster, Md.

19. 12/14 48 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH.....December 13, 1948 at 5:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19..... to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death.....Broncho pneumoniaDue to.....The above.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE.....James T. Monk, Deputy Medical ExaminerAddress.....Westminster Md M. D. or otherDate signed.....Dec 18/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-JEM

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 16 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

12373

74

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Dec. 18

(Date rec'd by registrar)

1948

P. H. H. H. H.

P. H. H. H. H.

P. H. H. H. H.

P. H. H. H. H.

P. H. H. H. H.

P. H. H. H. H.

P. H. H. H. H.

P. H. H. H. H.

P. H. H. H. H.

P. H. H. H. H.

P. H. H. H. H.

P. H. H. H. H.

P. H. H. H. H.

P. H. H. H. H.

P. H. H. H. H.

P. H. H. H. H.

P. H. H. H. H.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 18th

19

48, at 5-10⁰⁰ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 12

19

48

to

Dec 18

19

48

and that I last saw him alive on

Dec 18

19

48

Immediate cause of death

DURATION

Chronic Myocarditis

Due to

Sunt Arterio Sclerosis

Due to

Other conditions

Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

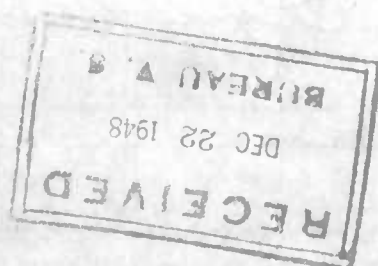
Address

Lyonsville Md

M. D. of other

Date signed

12/18/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County CarrollCity or town Shumville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 15 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County CarrollCity or town Rural Shumville
(If outside city or town limits, write RURAL and give nearest town)Street No. Shumville Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Shirley Roney7. Birth date of deceased (mo., day, yr.) Aug. 10, 1862 6.(c) If alive, give age 86 years8. AGE: Years 86 Months 4 Days 19 If less than one day hrs. min.9. Birthplace Virginia
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Retired12. Name J. W. Shifflett13. Birthplace ?14. Maiden name Yank15. Birthplace Yank16. Informant Leon ShifflettAddress Shumville, Md.17. Burial Date thereof 12-31-48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Morgan ChapelLocation W. Woodhull, Carroll Co., Md.18. Funeral director C. Harry ZeeAddress Shumville, Md.19. Dec 30 19 48 C. Harry Zee
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29 19 48 at 3 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-1-48 to 12-29-48and that I last saw him alive on 12-27-48 19 48Immediate cause of death myocarditis - chronic DURATION 5 yrs.decompensating.Due to hypertension yearsDue to arteriosclerosis years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James G. Saffell M. D. or otherAddress Persimmon Md. Date signed 12-29-48

RECEIVED

JAN 3 1949

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1246-12375

1. PLACE OF DEATH:

County Sykesville
City or town Carroll
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since Nov. 5, 1931
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? since Nov. 5, 1931

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George
City or town Mount Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2. (a) If veteran, name war _____

3. (a) FULL NAME

SMITH, Melvin

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) 1908(?)

8. AGE: Years 50 Months ? Days ? If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business _____

12. Name John Smith

13. Birthplace Virginia

14. Maiden name Marie

15. Birthplace Maryland

16. Informant Records of Springfield State Hospital
Address Sykesville, Md.

17. Burial Date thereof 1-3-49
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Springfield Hospital

Location Sykesville, Md.

19. Funeral director C. Harry Zuer

Address Sykesville, Md.

19. Jan 3 19 49 C. Harry Zuer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30 19 48 at 11:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1 19 47 to December 30 19 48
and that I last saw him alive on December 30 19 48

Immediate cause of death Liver cirrhosis DURATION 3 yrs

Due to _____

Due to _____

Other conditions Mental deficiency 50 yrs

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

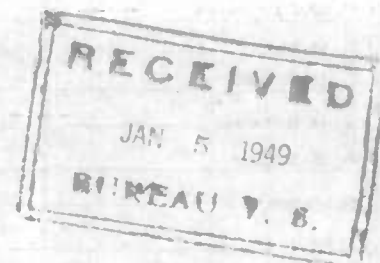
Martin Gross, M.D.
23. SIGNATURE Martin Gross, M.D.
M. D. or other

Address Sykesville, Md. Date signed 12-31-48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

12376

1. PLACE OF DEATH:

County Carroll
 City or town Sykesville, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 yr., 6 months, 15 days
 Hospital, institution, or street address where death occurred:
Springfield State Hospital
 How long in hospital or institution? 1 yr., 6 months, 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 222 W. Franklin Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war ☒

3. (a) FULL NAME

WILLIAM M. SMITH

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Widower

8.(b) Name of husband or wife Alice Mills
 6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) May 2, 1882
 8. AGE: Years 66 Months 7 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Pennsylvania
 (Town, county, and state)

10. Usual occupation H. handyman

11. Industry or business _____

12. Name John H. Smith

13. Birthplace Pennsylvania

14. Maiden name Bette Host

15. Birthplace Maryland

16. Informant Record, Springfield State Hospital

Address Sykesville, Maryland

17. Burial Date thereof Dec. 17, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Maryland

18. Funeral director Fred W. Kraiss

Address Hagerstown, Maryland

19. Dec. 15 19 48 Harry Heer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7: December 14 19 48 at 7:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 29 19 47 to December 14 19 48

and that I last saw him alive on December 14 19 48

Immediate cause of death Pulmonary tuberculosis DURATION 3 years

Due to _____

Due to _____

Other conditions Senile Psychosis, simple deterioration since April, '47

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

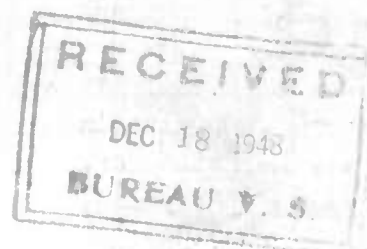
Whom did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Joseph H. Marshall, M.D. M. D. or other _____

Address Sykesville, Maryland Date signed 12/14/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12877

Reg. Dist. No. 76

I. PLACE OF DEATH:

County Carroll Co.
 City or town Westminster, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? about 26 years
 Hospital, institution, or street address where death occurred:
106 Penna Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Carroll
 City or town Westminster
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 106 Penna Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Lee Andrew Snyder

3. (b) Social Security Number

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Laura M.E. Grosse

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24 18738. AGE: Years 75 Months 1 Day 24 If less than one day hrs. min.9. Birthplace Carroll Co. Seister Church, Md.
(Town, county, and state)10. Usual occupation laborer (retired)

11. Industry or business

12. Name Daniel Snyder13. Birthplace Carroll Co. - Md.14. Maiden name Mary Catherine Seister15. Birthplace Carroll Co. - Md.19. Informant Mr. Sterling SnyderAddress 106 Penna. Ave. Westminster, Md.17. Burial Date thereof 12/21/48
(Burial, cremation, or removal) Which? (month) (day) (year)Cemetery or crematory Seister CemeteryLocation Rural near Westminster19. Funeral director J. E. Snyder, Jr.Address Wellst. - Westminster19. 12/18 19 48 L. K. Woodward, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18 - 48 at 3.02 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 40 to Dec 18 - 48 and that I last saw him alive on Dec. 17 - 48Immediate cause of death Myocarditis
Hypertension
DilatationDue to MyocarditisDue to Hypertension

Other conditions

Major findings of operations None

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. C. Jesmutter, M.D.Address Westminster, Md. N. D. or other Date signed 12-18-48

MARGIN RESERVED FOR BINDING

VS A15 9.45.17

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll
 City or town Sykesville, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 months, 19 days
 Hospital, institution, or street address where death occurred:
Springfield State Hospital
 How long in hospital or institution? 3 months, 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4312 Sidehill Road # 29
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____ ☒

3. (a) FULL NAME

ERICH BERNHARD STEIN

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced MARRIED
 6. (b) Name of husband or wife Hildegard Marie Kabisius
 8. (c) If alive, give age 57 years
 7. Birth date of deceased (mo., day, yr.) July 3, 1887
 8. AGE: Years 61 Months 5 Day 26 If less than one day _____ hr. _____ min.

9. Birthplace Germany
 (Town, county, and state)
 10. Usual occupation Laboratory Technician
 11. Industry or business _____
 12. Name Unknown
 13. Birthplace Germany
 14. Maiden name Unknown
 15. Birthplace Germany

16. Informant Record, Springfield State Hospital
 Address Sykesville
 17. Cremation Date thereof 12-31-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Louison Park
 Location 3801 Frederick Rd.
 18. Funeral director Harry H. Witzke
 Address 401 Edmondson Ave
 19. Dec. 31 1948 A. W. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29 19 48 at 4:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
September 10 19 48 to December 29 19 48
 and that I last saw him alive on December 29 19 48

Immediate cause of death
Bronchopneumonia DURATION 2 days
 Due to Generalized arteriosclerosis 2
myocardial degeneration 2
 Due to _____
 Other conditions Psychosis with 8 yrs.
cerebral arteriosclerosis
 (Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE Joseph H. Marshall, M.D. M. D. or other _____
 Address Sykesville, Maryland Date signed 12/29/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No.

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred.....

How long in hospital or institution?.....

3. (a) FULL NAME

4. Sex.....

5. Color or race.....

6. (a) Single, married, widowed, or divorced.....

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....

6. (c) If alive, give age..... years

8. AGE:

Years.....

Months.....

Days.....

If less than one day.....

hrs.....

min.....

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial.....

(Burial, cremation, or removal. Which?).....

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Dec 6 48

(Date rec'd by registrar)

19. 48

a.w. Redlich
c Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Dec 4th 19 48 at 10-10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 26 1937 to Dec 4th 19 48

and that I last saw him live on Dec 4th 19 48

Immediate cause of death.....

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, pub'c place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

Address.....

Date signed.....

M. D. or other

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 72

12380

468

1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial, cremation, or reposed, Which?

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

(Date rec'd by registrar)

19. 48

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec 30

19 48

at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1

1920

to Dec 30

19 48

and that I last saw him alive on

Dec 30

19 48

Immediate cause of death

carcinoma of

DURATION

Liver

Due to

Due to

Other conditions

heart condition

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Charles H. Kraybill

M. D. or other

Address

Hanover Pa

Date signed

Dec 31-48

MARGIN RESERVED FOR BINDING

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 7 1949

BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 74

CERTIFICATE OF DEATH

83a

12381

1. PLACE OF DEATH:

(a) County Carroll
 (b) City or town Stokesville
 (If outside city or town limits, write RURAL and give town)
 (c) Street address, hospital, or institution:
 (d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in this community (yrs., mos., or days) 8 years

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Carroll
 (c) City or town Stokesville
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. Sykesville T.O.
 (If rural give location)
 (e) If foreign born, how long in U. S. A.? _____ years

3 (a) FULL NAME

Theresa Louise Stone

3 (b) If veteran, name war

3 (c) Social Security

No.

4. Sex

F.

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Benjamin Stone

6 (c) If alive, give age

72 years

7. Birth date of deceased (mo., day, yr.)

Nov. 21, 1876

8. AGE:

Years

Months

Days

If less than one day

72

0

16

hr.

min.

9. Birthplace

Baltimore, Md.
 (Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

MOTHER FATHER

12. Name

Anthony Zamsnack

13. Birthplace

Austria

14. Maiden Name

Anna Pollack

15. Birthplace

Austria

16 (a) Informant

Benjamin Stone

(b) Address

Sykesville, Md.

17 (a)

Burial
 (Burial, cremation, or removal)

(b) Date thereof

12-11-48
 (month) (day) (year)

(c) Cemetery or crematory

Holy Cross

Location

B. A. Co. Md.

18 (a) Funeral director

C. M. Walz

(b) Address

Unionfield, Md.

19 (a)

Dec 8 1948
 (Date rec'd by registrar)

C. F. Fawcett
 Registrar

MEDICAL CERTIFICATION

20. Date of death Dec. 7th 1948, at 7:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 4, 1948, to Dec 7, 1948, and that I last saw him alive on Dec 6, 1948.

Immediate cause of death

Cerebral Hemorrhage

Duration

3 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
 (b) Date of occurrence
 (c) Where did injury occur? (City or town) (County) (State)
 (d) Did injury occur about home, on farm, industrial place, in public place? While at work?
 (Specify type of place)
 (e) Means of injury

23. Signature

Tom E. Martin

M. D. or other

Address

Pandalltown

Date signed 12/8/48

MARGIN RESERVED FOR BINDING

VS. A15.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 11 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

12382

Reg. Dist. No. 74

1. PLACE OF DEATH:

County... Carroll
 City or town... Sykesville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? since May 19, 1933
 Hospital, institution, or street address where death occurred:
Springfield State Hospital
 How long in hospital or institution? since May 19, 1933

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Washington
 City or town... Boonsboro
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

STOUFFER, Clayton

3. (b) Social Security Number

4. Sex... male
 5. Color or race... white
 6. (a) Single, married, widowed, or divorced... single
 6. (b) Name of husband or wife.....
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) August 7, 1912
 8. AGE: Years... 36 Months... 4 Days... 18 If less than one day
 hrs. min.

9. Birthplace... Maryland
 (Town, county, and state)
 10. Usual occupation... Farm helper
 11. Industry or business.....
 FATHER 12. Name... Isaac Stouffer
 13. Birthplace... Maryland
 MOTHER 14. Maiden name... Vernie V. Shoemaker
 15. Birthplace... Maryland

16. Informant... Records of Springfield State Hospital
 Address... Sykesville, Md.

17. Burial Date thereof... 12-28-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory... Boonsboro, Md.
 Location... Wm. F. Bart & Son
 18. Funeral director... Boonsboro, Md.
 Address... Boonsboro, Md.
 19. Dec. 26, 1948 C. Harry Wilson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... December 25 19... 48 at... 7:20 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
September 1 19... 47 to December 25 19... 48
 and that I last saw him alive on December 25 19... 48

Immediate cause of death... Disease of the coronary arteries
 DURATION... unknown
 Due to... Chronic myocarditis and
myocardial degeneration more than
5 months
 Due to...
 Other conditions... Schizophrenia
 (Include pregnancy within 3 months of death)

Major findings of operations...
 Date of op.
 Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of ...
 Where did injury occur? ... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) ...
 Means of injury... Injured at work? ...
Martin Gross, M.D.
 23. SIGNATURE... Martin Gross, M.D. M. D. or other
 Address... Sykesville, Md. Date signed... 12-25-48

UNITED STATES DEPARTMENT OF STATE
BUREAU OF CONSULAR AFFAIRS
OFFICE OF THE SECRETARY

RECEIVED
DEC. 28 1943
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? About 5 years
Hospital, institution, or street address where death occurred:
1 Ridge Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1 Ridge Road
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Louise Hintel Strube

3. (b) Social Security Number

4. Sex f. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Harry W. Strube
6. (c) If alive, give age 74 years
7. Birth date of deceased (mo., day, yr.) May 12, 1872
8. AGE: Years 76 Months 7 Days 17 If less than one day
..... hrs. min.

9. Birthplace Germany near Weir
(Town, county, and state)
10. Usual occupation home wife
11. Industry or business

12. Name Not Known
13. Birthplace
14. Maiden name Not Known
15. Birthplace

16. Informant Mr. Harry W. Strube
Address Ridge Road, Westminster, Md.
17. Burial, cremation, or removal. Which? Burial Date thereof Jan. 2, 49
(month) (day) (year)
Cemetery or crematory Methodist Church
Location near Westminster

18. Funeral director J. E. Myers, Jr.
Address 1111 1st St. Westminster, Md.
19. (Date rec'd by registrar) 1-2-49 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 29th 19 48 at 12:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from DEC 28th 19 48 to DEC 29th 19 48
and that I last saw him alive on DEC 29th 19 48

Immediate cause of death acute cardiac decompensation
DURATION 1 hr

Due to Cerebral Hemorrhage 18 hrs

Due to arteriosclerosis 5 yrs

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide
Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

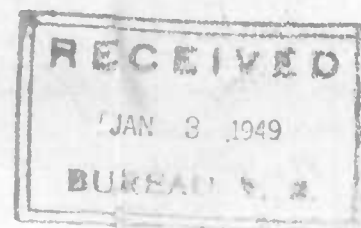
Means of injury Injured at work?

23. SIGNATURE Chas R Fout, MD
Address Westminster, Md. Date signed 12-30-48

MARGIN RESERVED FOR BINDING

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 76

12384

1. PLACE OF DEATH:

County.. Carroll Co.
 City or town.. Rural near Westminster
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? About 8 years
 Hospital, institution, or street address where death occurred:
R.D.#7 near Frysburg
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State.. Maryland County.. Carroll
 City or town.. Rural near Westminster
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.. R.D.#7 near Frysburg
 (If rural, give LOCATION)
 2.(a) If veteran, name war..

3. (a) FULL NAME

Elmer Stanley Strumsky

3. (b) Social Security Number

4. Sex M. 5. Color or race W. 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Hilda B. Strumsky
 6.(c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1891
 8. AGE: Years 57 Months 1 Days 2 If less than one day
 hrs. min.

9. Birthplace Baltimore Md.
 (Town, county, and state)

10. Usual occupation salesman

11. Industry or business

12. Name J. Louis Strumsky
 13. Birthplace Germany

14. Maiden name Mary Karcher
 15. Birthplace Cornish Mills, Balt. Co. Md.

16. Informant Mrs. Hilda B. Strumsky
 Address Westminster Md. R.D.#7

17. Burial, cremation, or removal. Which? Burial Date thereof 12/27/48
 (month) (day) (year)

Cemetery or crematory Guthrie Cemetery
 Location Westminster Md.

18. Funeral director J. S. Myers, Jr.
 Address Westminster Md.

19. 12/18 1948 L. Woodward
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17, 1948 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 12, 1948 to Dec. 17, 1948
 and that I last saw him alive on December 17, 1948

Immediate cause of death Myocardial degeneration DURATION 1 mo

Due to Pulmonary tuberculosis 15 yrs

Due to (far advanced)

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

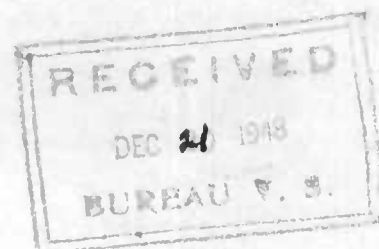
23. SIGNATURE E. Reese Willbans M.D.

Address Westminster Md. M. D. or other
 Date signed 12/17/48

MARGIN RESERVED FOR BINDING

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

12385

77

Reg. Dist. No.

1. PLACE OF DEATH:

County CarrollCity or town Hampstead
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarrollCity or town Hampstead
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Annie M Stiller

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M6. (b) Name of husband or wife Edward M Stiller

7. Birth date of deceased (mo., day, yr.)

Aug 10 - 18826. (c) If alive, give age 87 years

8. AGE:

Years

Months

Days

If less than one day

86413

hrs.

min.

9. Birthplace

md
(Town, county, and state)

10. Usual occupation

Hof

11. Industry or business

FATHER

12. Name

John Jungling

13. Birthplace

md

MOTHER

14. Maiden name

Amanda Reigle

15. Birthplace

md

16. Informant

Miss Georgia Stiller

Address

Hampstead Md

17.

Burial

Date thereof

12-26-48
(month) (day) (year)

Cemetery or crematory

Snyderburg

Location

Carroll Co Md

18. Funeral director

Edw E Tipton

Address

Hampstead Md

19.

Dec. 24

19

48

John S. Hughes Jr.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23 19 48 at 6:30 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 4 19 44 to Dec 23 19 48and that I last saw him alive on Dec 22 19 48

Immediate cause of death

Chronic myocarditis.

DURATION

Due to

Chronic-sclerotic Cardio-Vascular

Due to

Coronary

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Injured at work?

Means of injury

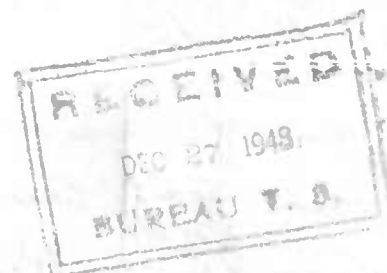
23. SIGNATURE

Joseph E Bush MD

M. D. or other

Address

Hampstead MdDate signed 12-23-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 128864 74

1. PLACE OF DEATH:

County Carroll
 City or town Sykesville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 years, 7 months, days
 Hospital, institution, or street address where death occurred:
Springfield State Hospital
 How long in hospital or institution? 5 years, 7 months, days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Balto. Co
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2813 Oakercrest Avenue #14
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

LILLIE MAE THOMPSON

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

SINGLE

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

March 12, 1874

8. AGE:

Years

Months

Days

If less than one day

74

8

29

hrs.

min.

9. Birthplace Howard County, Maryland
(Town, county, and State)10. Usual occupation Practical Nursing

11. Industry or business

MOTHER FATHER

12. Name

William Thompson

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant Record, Springfield State HospitalAddress Sykesville, Maryland17. Burial
(Burial, cremation, or removal, which?)

Date thereof

12-14-48
(month) (day) (year)

Cemetery or crematory

Landon Park

Location

Balto. Md.

18. Funeral director

W.E. Cook, Inc.

Address

1317 St Paul St.19. Dec. 11 19 48
(Date rec'd by registrar)C. H. Wynn, Jr.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11, 1948 at 7:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 519 43

to

Dec. 11,19 48

and that I last saw her alive on

Dec. 10,19 48

Immediate cause of death

Pulmonary Tuberculosis

DURATION

5 yrs.

Due to

Due to

Other conditions

Senile Psychosis

(Include pregnancy within 3 months of death)

5 yrs.

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Joseph H. Marshall, M.D.

M.D. or other

Address Sykesville, Maryland

Date signed

12/11/48

RECEIVED

DEC 14 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

12387

94a

1. PLACE OF DEATH:

County CarrollCity or town Lysburnville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County CarrollCity or town Lysburnville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Dorsey C. Lusher

3. (b) Social Security Number

213-10-23934. Sex M 5. Color or race W 6.(b) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Catherine Cross

B.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Dec. 22, 19108. AGE: Year 37 Months 11 Days 21 If less than one day _____ hr. _____ min.9. Birthplace Md.
(Town, county, and state)10. Usual occupation Operator11. Industry or business Shipping Station12. Name Charles W. Lusher13. Birthplace Md.14. Maiden name Minnie Hall15. Birthplace Md.18. Informant Mrs. Catherine LusherAddress Lysburnville, Md.17. Burial Date thereof 12-16-48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. John'sLocation Beltsville City, Md.18. Funeral director C. Harry WeaverAddress Lysburnville, Md.19. Dec. 15, 1948 C. Harry Weaver
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 13, 1948, at 9 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1947 to Dec. 13, 1948and that I last saw him alive on Dec. 13, 1948Immediate cause of death Cardiac collapse DURATION 15 minutesDue to embolism of coronary artery

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Manner of injury _____ Injured at work? _____

23. SIGNATURE [Signature] M. D. or other _____Address Lysburnville Date signed 12/13/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 18 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12388

Reg. Dist. No. 79

1. PLACE OF DEATH:

County Carroll
City or town Keymar Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State..... County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

Mrs. Emma S. Valentine

3. (b) Social Security Number

none

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife Robert S. Valentine
6.(c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.) April 3, 1876
8. AGE: Years 72 Months 8 Days 21 If less than one day..... hrs. min.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 24 1948 at..... M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 25 1946 to December 24 1948
and that I last saw him alive on December 24 1948

Immediate cause of death.....
Chronic myocarditis

DURATION

Due to.....
Due to.....

Other conditions Atherosclerosis
Chronic bronchitis
(Include pregnancy within 3 months of death)

Major findings of operations.....
none

Autopsy results.....
not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur?.....
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?).....
Means of injury..... Injured at work?

23. SIGNATURE M. Franklin Birch M. I. or other
Thermont, Md. Date signed 12/25/48

9. Birthplace.....
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business.....
12. Name Jeremiah Pittinger
13. Birthplace md
14. Maiden name Georgiann Martin
15. Birthplace md
16. Informant Robert S. Valentine
Address Keymar R.D.
17. Burial Date thereof Dec 27, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Keyville
Location Keyville, md
18. Funeral director Flt. Guss Son
Address Taneytown, md
19. 12-26 1948 Ray M. Powell
(Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

VS A15 9-45-7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 30 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 79

1. PLACE OF DEATH:

County Carroll
 City or town Henryton, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 months, 5 days
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
 How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore -23-
 City or town Baltimore -23-
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 205 Vincent Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

GEORGE ELLSWORTH WASHINGTON

3. (b) Social Security Number

218-10-7411

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married (Sep.)

6. (b) Name of husband or wife Emma Washington

6. (c) If alive, give age 27 years
 7. Birth date of deceased (mo., day, yr.) March 28, 1913

8. AGE:

Years

Months

Days

If less than one day

35

3

2

hrs.

min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation Bar Tender

11. Industry or business

12. Name William Washington13. Birthplace Unknown14. Maiden name Ruth Smith15. Birthplace Unknown16. Informant Deceased

Address

17. Buried Date thereof 1-3-1949
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director Mrs. Kate R. Williams

Address

19. Dec. 30, 1948 Albert R. Schrock
 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30, 1948 at 3:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
August 25, 1948 to Dec. 30, 1948
 and that I last saw him alive on December 30, 1948

Immediate cause of death

Pulmonary Tuberculosis

DURATION

March 1948

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Peaken Hoffman, M.D. M. D. or otherAddress Henryton, Maryland Date signed 12-30-48

RECEIVED

JAN 3 1949

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and legibly. The street age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll
 City or town Rural Westminster
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?...

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Carroll
 City or town Rural Westminster
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Alice E. Welk
 4. Sex FEMALE Color or race White 6.(a) Single, married, widowed, or divorced Married
 Female White Married

3. (b) Social Security Number

None

6.(b) Name of husband or wife Theodore W. Welk
 7. Birth date of deceased (mo., day, yr.) Sept. 7, 1870
 6.(c) If alive, give age... years

8. AGE: Years 78 Months 3 Days 13 If less than one day
 hrs. min.

9. Birthplace Maryland
 (Town, county, and state)

10. Usual occupation Housewife
Own Home

11. Industry or business

MOTHER FATHER 12. Name Augustus Sittig
 13. Birthplace Germany

14. Maiden name Dorothy Helwig
 15. Birthplace Maryland

16. Informant Mr. Theodore W. Welk
 Address Westminster, R #2, Md.

17. Burial Date thereof Dec. 22, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Pleasant Valley
 Location Pleasant Valley, Md.

18. Funeral director C.O. Fuss & Son
 Address Taneytown, Md.

19. 12/21 19 48 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20, 1948 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from about Nov. 15, 1947 to Dec. 20, 1948
 and that I last saw him alive on Dec. 18, 1948

Immediate cause of death Cerebral Hemorrhage DURATION Several
Vascular Disease post year
3 years

Due to

Due to

Other conditions Diabetes
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. B. Billingslea, M.D. M. D. or other
 Address Westminster, Md. Date signed 12.20.48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll
 City or town Henryton, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 month, 3 days
 Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
 How long in hospital or institution? Colored Branch

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore 2
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1124 E. Lombard Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war. _____ ✓

3. (a) FULL NAME

Alexander White

3. (b) Social Security Number

225-03-0707

4. Sex Male 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Single
 8. (b) Name of husband or wife _____
 8. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) August 15, 1900
 8. AGE: Year 48 Month 3 Days 24 It less than one day _____ hr. _____ min.

9. Birthplace Petersburg, Virginia
 (Town, county, and state)
 10. Usual occupation Laborer
 11. Industry or business _____
 12. Name Bill White
 13. Birthplace Virginia
 14. Maiden name Mariah (unknown)
 15. Birthplace Sussex County, Virginia

16. Informant Decensed
 Address _____
 17. Burial Date thereof Dec 14/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Petersburg Va
 Location va
 18. Funeral director Elmer O Wilson
 Address 1000 Brantley
 19. December 9, 1948
 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH December 9, 1948 at 2:25 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
November 6, 1948, to December 9, 1948
 and that I last saw him alive on December 9, 1948

Immediate cause of death Pulmonary Tuberculosis
 DURATION June 1943

Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Reuben Hoffman, M.D.
 M. D. or other _____
 Address Henryton, Maryland Date signed 12-9-48

RECEIVED

DEC 14 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

443

131a

17392

83

Reg. Dist. No.

1. PLACE OF DEATH:

County... CarrollCity or town... Rural--Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... CarrollCity or town... Rural--Sykesville

(If outside city or town limits, write RURAL and give nearest town)

Street No... Dorsey's Crossroads

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

CLARENCE G. WILSON

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife... Mary E. Wilson
deceased

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

Feb'y 29, 1868

8. AGE:

Years

80

Months

9

Days

22

If less than one day

.....hrs.min.

B. Birthplace

Carroll Co. Maryland

(Town, county, and state)

Farmer

1D. Usual occupation

retired

11. Industry or business

12. Name... Cornelius Wilson13. Birthplace... Maryland14. Maiden name... Narcissus Warfield15. Birthplace... Maryland16. Informant... Theodore S. WilsonAddress... Sykesville, Md.17. Burial... 12-23-48

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory... Messiah LutheranLocation... Berrett, Carroll Co. Md.18. Funeral director... C. M. WaltzAddress... Winfield, Md.19. Dec 23
(Date rec'd by Registrar)19. 48
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH... December 21 1948 at 11:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1940

18.....

to Dec. 211948and that I last saw him alive on Dec. 21 1948

Immediate cause of death

SenilityCardiac collapseDue to hypertensive cardiovascular disease with myocardial infarctionBasic chronic interstitial nephritis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. H. Lawmsh. M.D.

M. D. or other

Date signed... December 21, 1948

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

FEB 11 1949

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 123158

CERTIFICATE OF DEATH 92d

1. PLACE OF DEATH:

(a) County Carroll
 (b) City or town Salem
 (If outside city or town limits, write RURAL and give town)
 (c) Street address, hospital, or institution:
 (d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in this community (yrs., mos., or days) 40 y r

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Maryland (b) County Carroll
 (c) City or town Salem
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. Rural -- Westminster
 (If rural give location)
 (e) If foreign born, how long in U. S. A. ? _____ years

3 (a) FULL NAME

LILY G. WOLF

3 (b) If veteran, name war

3 (c) Social Security
 No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

George W. Wolf

6. (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) March 7, 1885

8. AGE:

Years

63

Months

9

Days

21

If less than one day

hr.

min.

9. Birthplace Carroll Co. Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER
 MOTHER

12. Name

Joseph Niner

13. Birthplace

Maryland

14. Maiden Name

Hannah Logue

15. Birthplace

Maryland

16 (a) Informant

Mr. Geo. W. Wolf

(b) Address

R.D. Westminster, Md.

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

12-31-48

(c) Cemetery or crematory

Trinity Lutheran

Location

Smallwood, Carroll Co. Md.

18 (a) Funeral director

C. M. Waltz

(b) Address

Winfield, Md.

19 (a) 12-30-48
 (Date rec'd by registrar)

(b)

E. M. Farver
Local

Registrar

MEDICAL CERTIFICATION

20. Date of death Dec. 25, 1948, at 9:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1948, to Dec. 25, 1948, and that I last saw him alive on Dec. 27, 1948.

Immediate cause of death

Chronic Vascular Heart Dis

Duration

Due to

Broken Compensation

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide
 (b) Date of occurrence
 (c) Where did injury occur? (City or town) (County) (State)
 (d) Did injury occur about home, on farm, industrial place, in public place? While at work?
 (Specify type of place)
 (e) Means of injury

23. Signature

Mr. E. Martin
Randallstown

M. D. or other

Date signed 12/29/48

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 5 1949

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Baltimore CarrollCity or town Sykesville (Rural)
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 hrs.Hospital, institution, or street address where death occurred:
—How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore CarrollCity or town Sykesville (Rural)
(If outside city or town limits, write RURAL and give nearest town)Street No. Liberty Road
(If rural, give LOCATION)2.(e) If veteran, name war —

3. (a) FULL NAME

Baby Boy Yingling, HOWARD GEORGE

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced S6. (b) Name of husband or wife —7. Birth date of deceased (mo., day, yr.) December 9th 19486. (c) If alive, give age — years8. AGE: Years — Months — Days — If less than one day 2 hrs. mo. —9. Birthplace Sykesville, Balt. Co., Md.
(Town, county, and state)10. Usual occupation —11. Industry or business —

FATHER

12. Name Howard Yingling13. Birthplace Carroll Co., Md.

MOTHER

14. Maiden name Margaret Ridgely15. Birthplace Elcheater, Balt. Co., Md.16. Informant Howard YinglingAddress Sykesville, Md.17. Burial Date thereof Dec. 10 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory FreedomLocation Carroll Co., Md.18. Funeral director Harry KeenAddress Sykesville, Md.19. Dec. 10 1948 Harry Keen
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9th 1948 at 8:00 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/9 1948 to 12/9 1948 and that I last saw him alive on 12/9/48Immediate cause of death Cerebral Anoxia

DURATION

2 hrs.Due to Prematurity2 daysDue to —Other conditions —

(Include pregnancy within 8 months of death)

Major findings of operations —Date of op. —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Martin E. Strobel, M.D. M. D. or otherAddress Reisterstown, Md. Date signed 12/9/48

RECEIVED

RECEIVED

RECEIVED

DEC 15 1948

BUREAU V. S.